

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

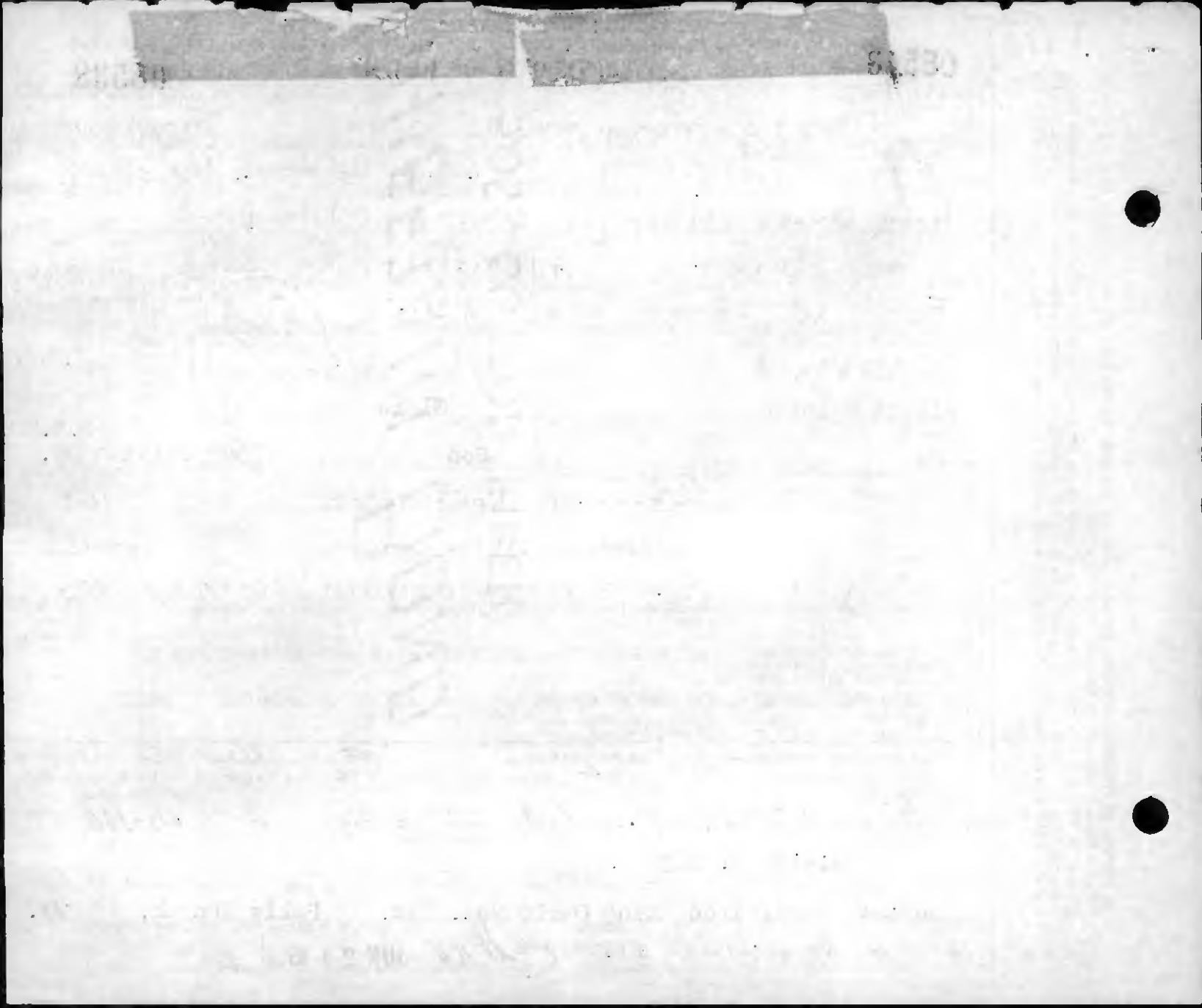
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember to file this on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

Item #12 Film #10326 6/20/66 118538

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2304 Colston Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital			
3. NAME OF DECEASED (Type or print)	First Sarah	Middle A	Last Berstadt
4. DATE OF DEATH	Month June	Day 20	Year 1966
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	8. DATE OF BIRTH 7/31/82
F	W	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	9. AGE (in years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Melnick		14. MOTHER'S MAIDEN NAME Clara	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Son
		Address 2304 Colston Dr.	
S.S. MD		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>			
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i>			
DUE TO (c) <i>Hypertensive Arteriosclerotic heart disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <u>0/19</u> 1966, to <u>6/20</u> 1966, that (I) (we) last saw the deceased alive on <u>0/19</u> 1966, and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Blaine H. Eig</i>		22b. DATE SIGNED 6/20/66	
22c. PHYSICIAN'S NAME (Type) Blaine H. Eig		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/66	
23c. NAME OF CEMETERY OR CREMATORIUM King David Mem. Gar.		23d. LOCATION (City, town or county) Falls Church, Va.	
24. FUNERAL DIRECTOR B. Langansky & Sons		ADDRESS 3501-14th St NW	25a. REC'D BY REGISTRAR DATE JUN 21 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08539

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 3 wks.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oakhaven Nursing Home		e. STREET ADDRESS 1357 Taylor St., N.W.		d. STREET ADDRESS 1357 Taylor St., N.W.	
e. STREET ADDRESS 1357 Taylor St., N.W.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g. DATE OF DEATH JUNE 8 1966	
3. NAME OF DECEASED (Type or print) ANNIE		First MIDDLE ALBERT		4. DATE OF DEATH JUNE 8 1966	
5. SEX Fe		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years at birthday) 84 yrs.		10b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (State or foreign country) New Jersey		10b. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Plotka		14. MOTHER'S MAIDEN NAME TOBA REUFIELD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y or N, unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Oakhaven Nursing Home Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Belden R. Reap, M.D. June 8, 1966		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 6-10-66		23c. NAME OF CEMETERY OR CREMATORIUM MT. LEBANON CEMETERY		23d. LOCATION (City, town or county) HYATTSVILLE MD	
24. FUNERAL DIRECTOR B. DANZANSKY & SONS		25a. ADDRESS WASHINGTON D.C.		25b. REC'D BY REGISTRAR JUN 13 1966	
25c. REGISTRAR'S SIGNATURE Charles Judge					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN Tb <i>2 DAYS</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 15-1</i>	
3. NAME OF DECEASED (Type or print) <i>Minnie G. Godley</i>		First <i>Minnie</i>	Middle <i>G. Godley</i>
4. DATE OF DEATH <i>June 3 1966</i>	Month <i>June</i>	Day <i>3</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>JAN 8, 1887</i>	9. AGE (In years lost birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Chief Operator Telephone Co.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Telephone Co.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Beaufort, North Carolina</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>NATHAN R. Godley</i>	14. MOTHER'S MAIDEN NAME <i>Sara ANN DICKENSON</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>291-01-5231</i>	17. INFORMANT <i>Mrs. B. BAILEY</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Diabetic atherosclerosis</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>June 3 1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April 1956</i> to <i>2 June 1966</i> that (I) (we) last saw the deceased alive on <i>2 June 1966</i> , and that death occurred at <i>6:55 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Herbert Martyn</i>		22b. DATE SIGNED <i>3 June 66</i>	
22c. PHYSICIAN'S NAME (Type) <i>HERBERT MARTYN JR</i>	22d. ADDRESS <i>4740 Chevy Chase Dr. C.C. Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>REMOVED 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedaryxx Grove Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>New Bern, North Carolina</i>
24. FUNERAL DIRECTOR <i>John Thomas</i>	ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	25a. RECD BY REGISTRAR <i>JUN 8 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Missouri</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>34 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kansas City, Missouri</b>		d. STREET ADDRESS <b>10712 Spruce St.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Arthur Earl ANDREWS</b>		First	Middle	Last	4. DATE OF DEATH June 3 1966	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1919</b>	9. AGE (In years (at birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Leonard Earl Andrews</b>				14. MOTHER'S MAIDEN NAME <b>Mary Marie Smith</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <b>yes 1944-1966</b>		16. SOCIAL SECURITY NO. <b>496-09-0971</b>		17. INFORMANT <b>Service Record, U. S. Navy</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transitional Cell Carcinoma, urinary bladder</b> 1810 DUE TO with widespread metastases						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>April 30</b> , 1966, to <b>June 3</b> , 1966, that (1) (we) last saw the deceased alive on <b>June 3</b> , 1966 and that death occurred at <b>100P M</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>M. Edson</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>6 June 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>M. Edson, M. D.</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/7/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>APPANOOSOE</b>		23d. LOCATION (City or Town) (County) (State) <b>DOUGLAS CO. KANSAS</b>		
24. FUNERAL DIRECTOR <b>W.W. Chambers Co., 1400 Chapin St., N. W./</b>		ADDRESS <b>D.C.</b>		25a. REC'D. BY REGISTRAR <b>JUN 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Jessie Edson Judge</b>		

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH. a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		b. COUNTY <b>Montgomery</b>				
c. LENGTH OF STAY IN 1b <b>6 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7008 West Greenvale Parkway</b>		d. STREET ADDRESS <b>7008 West Greenvale Pkwy.</b>				
3. NAME OF DECEASED (Type or print) <b>OSCAR L. ANDREWS</b>	First <b>OSCAR</b>	Middle <b>L.</b>	4. DATE OF DEATH <b>JUNE 17 1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1876</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			
13. FATHER'S NAME <b>John Andrews</b>		14. MOTHER'S MAIDEN NAME <b>Alice Sayler</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-24-7977</b>	17. INFORMANT Mrs. Alice L. Meaney same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>		6 yrs				
(c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		10 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED Whila <input type="checkbox"/> Not Whila <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>88</b>	(County) <b>MD</b>	(State) <b>MD</b>
21. I certify that (I) (his hospital) attended the deceased from <b>MAY 1966</b> to <b>JUNE 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>JUNE 17, 1966</b> , and that death occurred at <b>8P.M.</b> from the causes and on the date stated above.				22b. DATE SIGNED		
22a. SIGNATURE <b>B.R. Cooperman</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>B.R. Cooperman, M.D.</b>		22d. ADDRESS <b>1302-18 St. NW. Wash. DC.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 20, 1966</b>	23c. NAME OF CEMETERY <b>Mount Olivet</b>	23d. LOCATION (City, town or county) <b>Washington, D. C.</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>3821-14th St. N.W. Wash DC</b>	25a. REC'D BY REGISTRAR <b>JUN 20 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

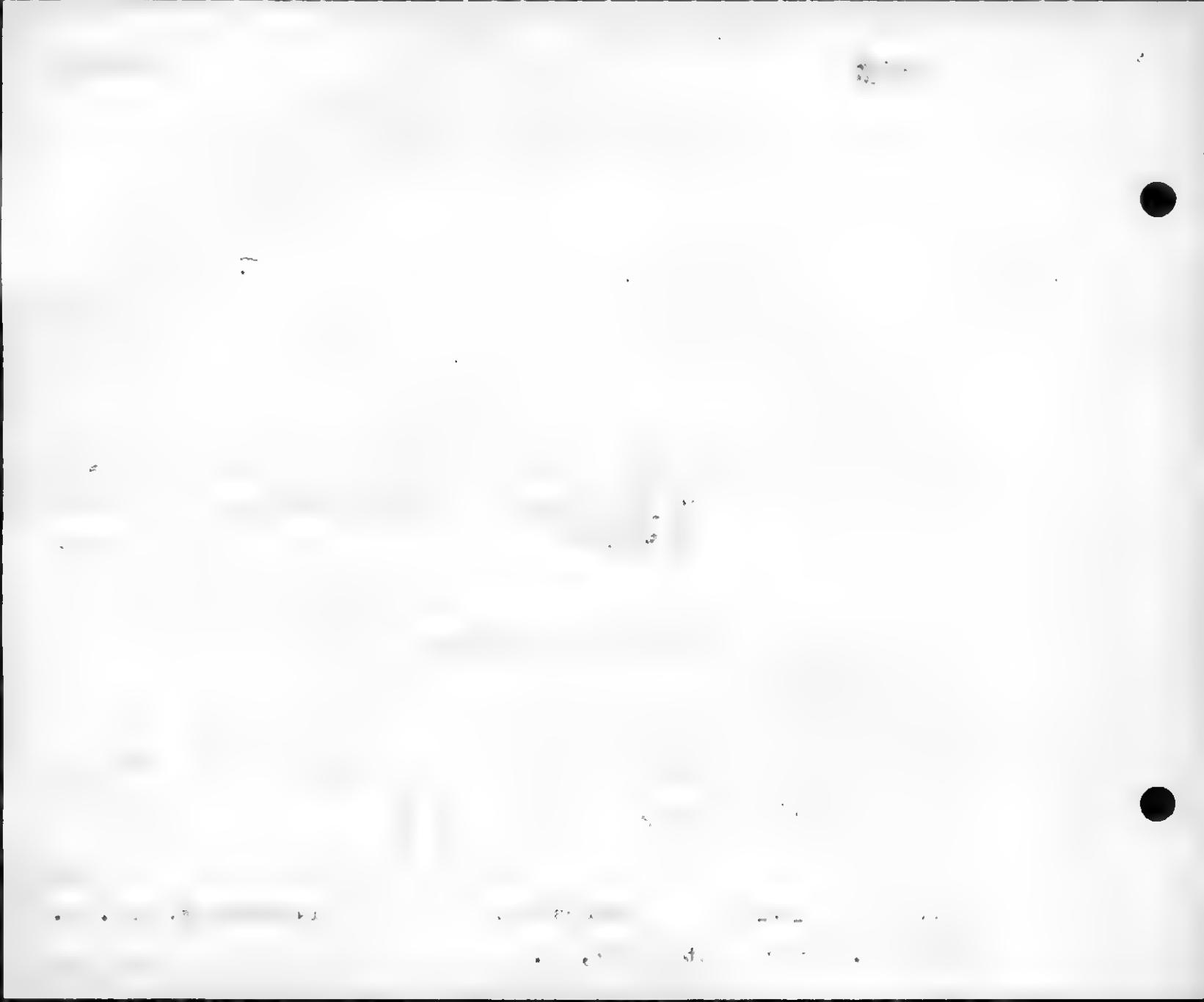
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN b. <i>D.O.A</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHEVY CHASE</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>4821 Debussy Parkway</i>	
3. NAME OF DECEASED (Type or print) <i>M. ESTHER Armstrong</i>		4. DATE OF DEATH <i>JUNE 25 1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>W. FRANK. Lumphrey.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>German town Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John H. Lumphrey</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASHD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) <i>ASHD</i>	
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. INTERVAL BETWEEN DEATH AND DEATH <i>1 minute</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Diabetes mellitus</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bethesda</i>		20f. (City or town) (County) (State) <i>Bethesda</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>June 25 1966</i> to <i>June 25 1966</i> that (I) (we) last saw the deceased alive on <i>June 25 1966</i> and that death occurred at <i>Bethesda</i> M, from causes and on the date stated above.		22b. <i>4/25/66</i>	
22a. SIGNATURE <i>Key H. Shavers</i>		22c. ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>8218 Wisconsin Ave</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>6-28-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Laytonsville</i>	
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>		23d. LOCATION (City or Town) (County) (State) <i>Laytonsville, Mont. Md.</i>	
ADDRESS <i>Laytonsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 29 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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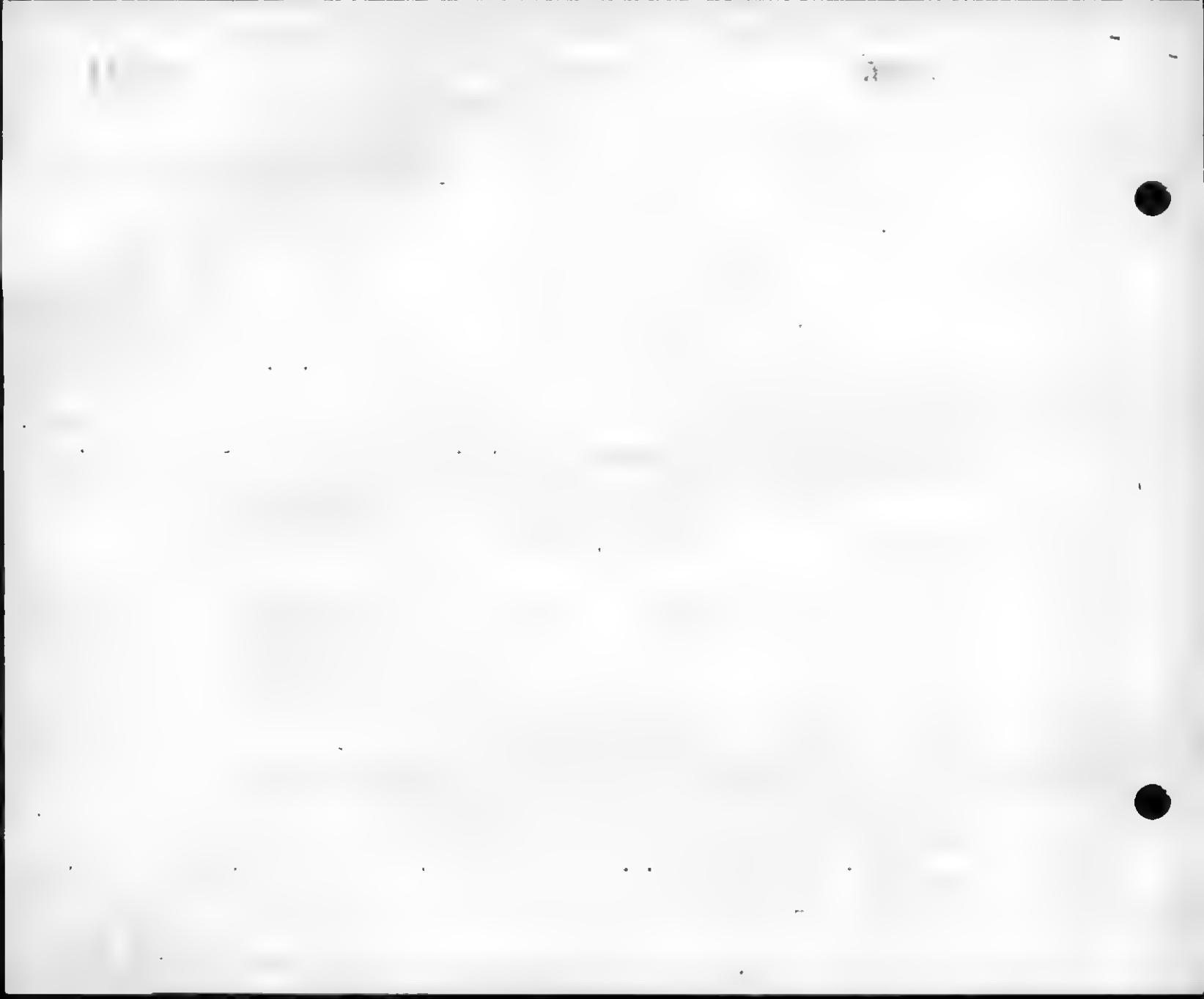
08554

## CERTIFICATE OF DEATH

08544

1 **HOSPITAL OR ATTENDING PHYSICIAN:** This now requires that the death certificate be executed within 24 hours after death.2 **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Italy	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)	c. LENGTH OF STAY IN lb 112 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXIX Parco Schisa, Villa #13	d. STREET ADDRESS 51,500 KM / / Arco Felice, Italy
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isabel	First	Middle Jene	Last Bacon
4. DATE OF DEATH June 23 1966	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 6, 1928	9. AGE (in years last birthday) 30 yrs	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 17
10a USLAI OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
13. FATHER'S NAME Harry D. Wolfe		14. MOTHER'S MAIDEN NAME Isabel Baldwin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no	16. SOCIAL SECURITY NO. N/A	17. INFORMANT Mrs. L. L. Stratton, 7103 Ridgeway Ave.,/	Address Chevy Chase, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the right breast with metastases, DUE TO bilateral bronchial pneumonia, and obstructive jaundice. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from March 2, 1966, to June 23, 1966 that (s) (we) last saw the deceased alive on June 23, 1966, and that death occurred at 6:40AM, from causes and on the date stated above.			
22a. SIGNATURE <i>J. E. Zimmerman</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED June 24, 1966
22c. PHYSICIAN'S NAME (Type) J. E. ZIMMERMAN, M.D.	22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-27-66	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Maryland	ADDRESS Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE JUN 29 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08555

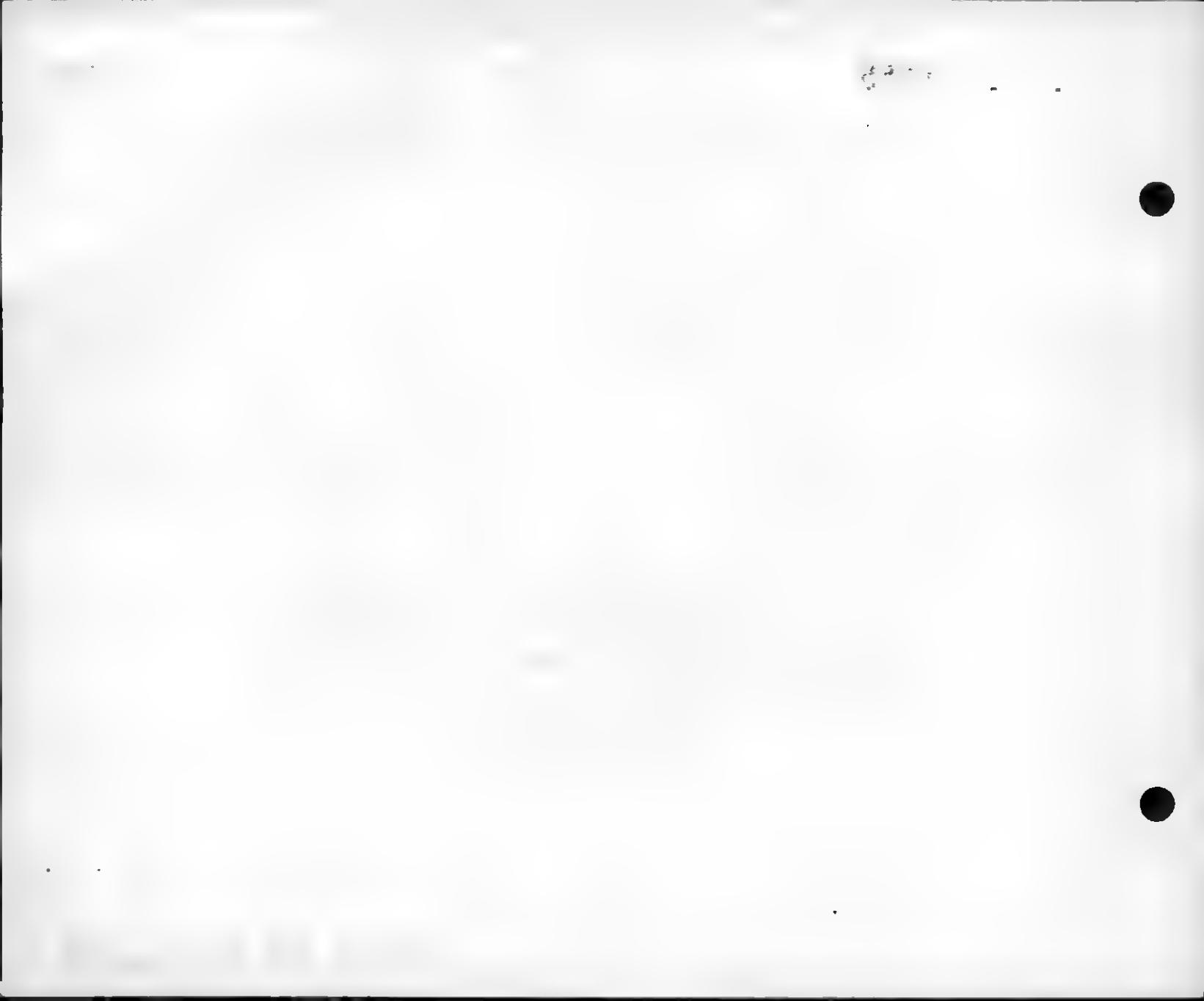
## CERTIFICATE OF DEATH

085545

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>9915 HARROGATE Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>IRENE</u>		First <u>I</u>	Middle <u>R</u>
4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1966</u>	5. AGE (In years last birthday) <u>42</u> yrs.	6. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	7. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
8. SEX <u>F</u>	9. COLOR OR RACE <u>W</u>	10. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH <u>12/13/23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>SHELBY Co. - ALABAMA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Edwin Haynes</u>		14. MOTHER'S MARRIED NAME <u>Nannie Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>(husband)</u> Address <u>BETHESDA</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
23. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		24. PLACE OF INJURY (Name, farm, factory street, office bldg, etc.)	
25. I certify that (I) (this hospital) attended the deceased from <u>5/31</u> , 1966 to <u>6/13</u> , 1966, and that death occurred at <u>3:50 AM</u> , from causes and on the date stated above.		26. DATE SIGNED <u>6/13/66</u>	
27. SIGNATURE <u>Robert G. Brewer</u>		28. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md. 20014</u>	
29. PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER</u>		30. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
31. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		32. DATE THEREOF <u>6/16/66</u>	
33. NAME OF CEMETERY OR CREMATORIAL <u>Elmwood Cemetery</u>		34. LOCATION (City or Town) <u>Fairfax, Alab.</u> County <u>Alab.</u> State <u>Alab.</u>	
35. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		36. ADDRESS <u>1321 Rockville Pike, Rockville, Md.</u>	
37. REC'D BY REGISTRAR <u>JON 15 1966</u>		38. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

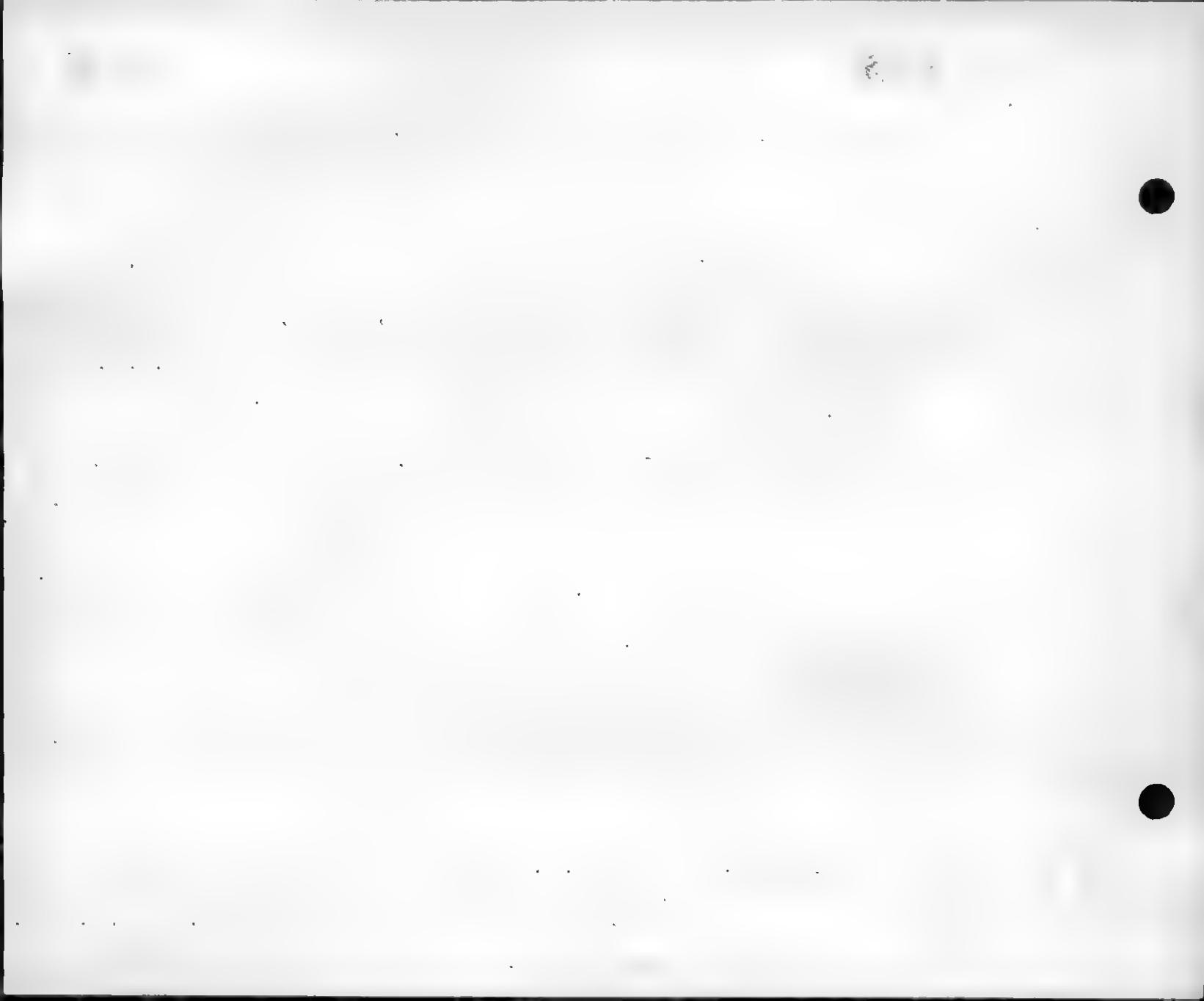
08546

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.M  
H. R. D.

COROL C.R. NOTARIZED

PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fairland Nursing Home</b>	
3. NAME OF DECEASED (Type or print) <b>IRENE F. BARTON</b>		4. DATE OF DEATH <b>June 25, 1966</b>	Month Day Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1902</b> 63 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>department store</b>	
13. FATHER'S NAME <b>Joseph I. LaSalle</b>		14. MOTHER'S MAIDEN NAME <b>Clara May Hudson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-12-4808</b>	
17. INFORMANT <b>Wilirene B. Hettenhouser Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY DEPRESSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>None</b>	
+43X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>CELEBRAL VASC. ACC.</b>		1 DAY	
DUE TO (b) <b>CELEBRAL VASC. ACC.</b>		DUE TO (c) <b>HYPERTENSIVE CARD. VASC. DIS.</b>	
DUE TO (c) <b>HYPERTENSIVE CARD. VASC. DIS.</b>		8 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CREMIA, LONGSTANDING ARTERIAL SCLEROSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 1, 1966</b> to <b>JULY 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>JULY 25, 1966</b> , and that death occurred at <b>M</b> , from causes and on the date stated above		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Richard P. Delaney, M.D.</b>		22d. ADDRESS	
23d. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/29/66</b>	
24. FUNERAL DIRECTOR Francis Gasch's Sons		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill</b>	
VR A15 (4) 20 M 1/68		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JUN 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please, remove carbon papers. Pages 1 and 2, director, page 3, should be detached for use as the burial/transit permit. Then please, remove carbon papers. Pages 1 and 2, director, page 3, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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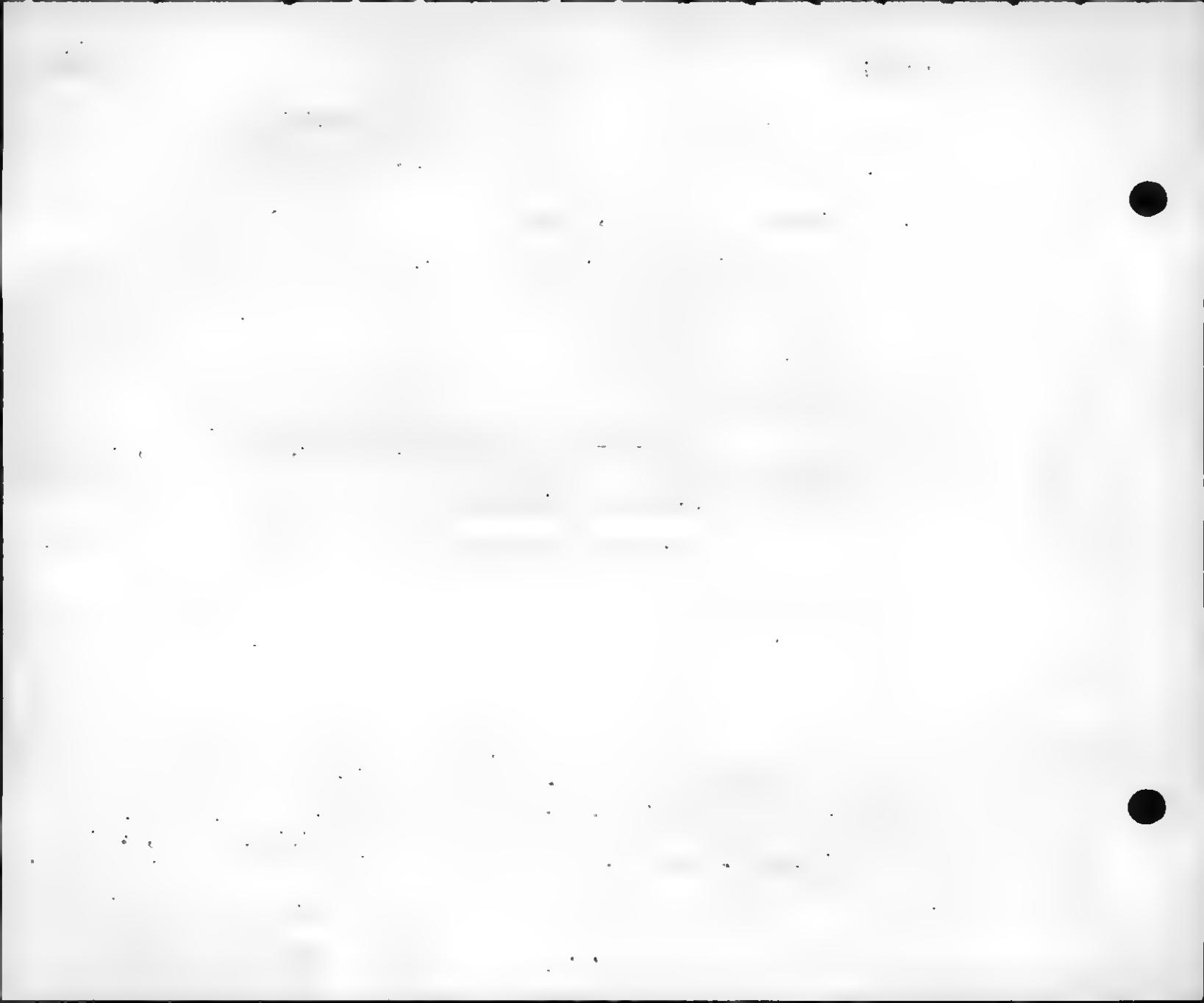
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

118547

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>William Nathan Beckner</b>		First <b>William</b>	Middle <b>Nathan</b>	Last <b>Beckner</b>	4. DATE OF DEATH <b>June 1 1966</b>	Month <b>June</b>	Day <b>1</b>	Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 May 1908</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John William Beckner</b>		14. MOTHER'S MAIDEN NAME <b>Izatta Grayer</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>235-28-5826</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH							
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>(b) Congenital Aortic stenosis</b>		<b>58 Years</b>							
DUE TO <b>(c)</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Aortic valve replacement</b>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 May 1966</b> , to <b>1 June 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1 June 1966</b> , and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above.		PM 22b. DATE SIGNED <b>2 June 1966</b>							
22a. SIGNATURE <b>Robert L. Reis</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
22c. PHYSICIAN'S NAME (Type) <b>Robert L. Reis, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6/3/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>D.C.</b>		23d. LOCATION (City, town or county) (State) <b>Beckley, West Virginia</b>			
24. FUNERAL DIRECTOR <b>FRAZIERS FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



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FOR STATE  
HEALTH DEPT.

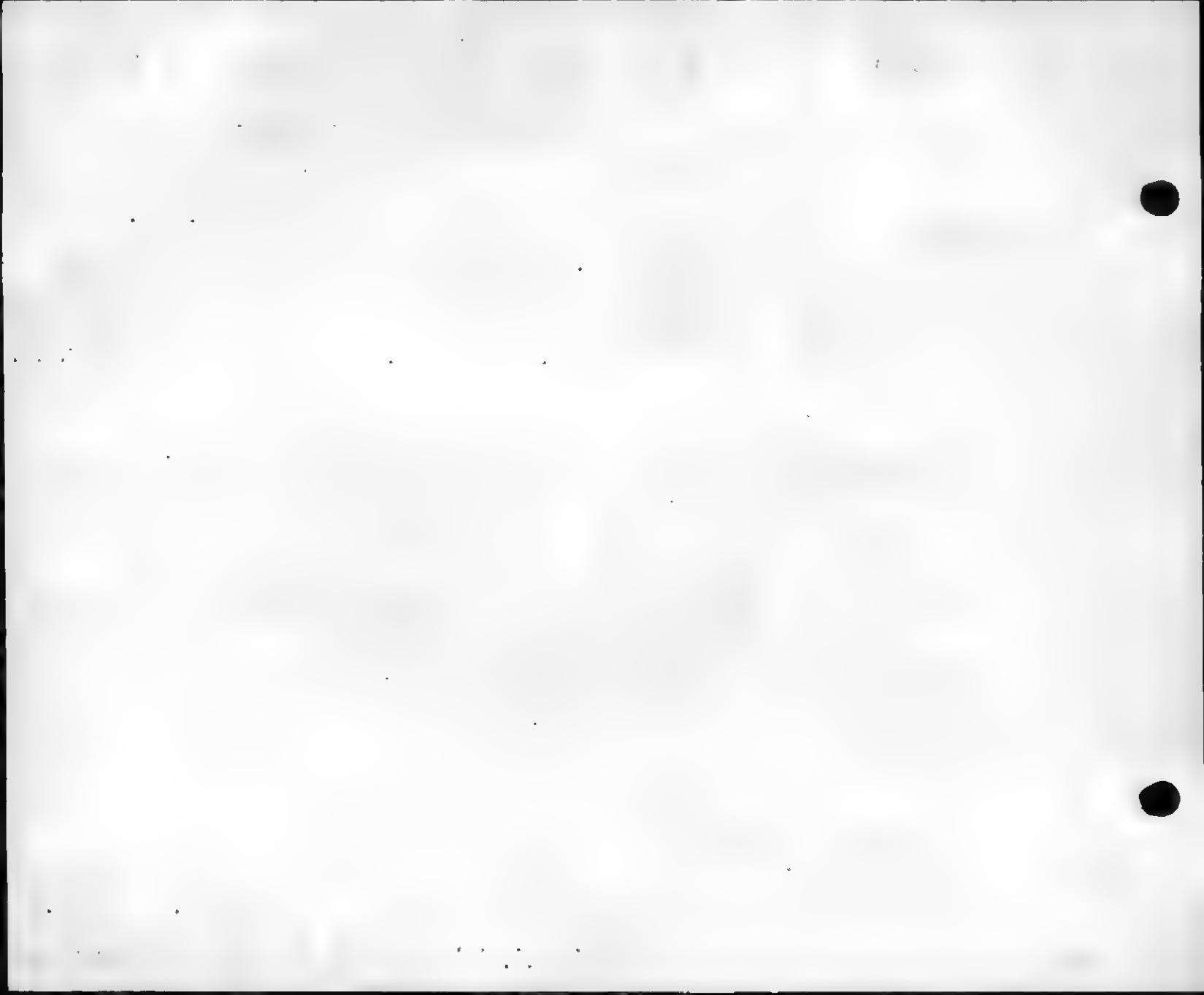
TO DUTY EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Items 10a, 14, 15, 21, 22, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 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905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 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1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1420, 1421, 1422, 1423, 1424, 1425, 1426, 1427, 1428, 1429, 1420, 1421, 1422, 1423, 1



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08559

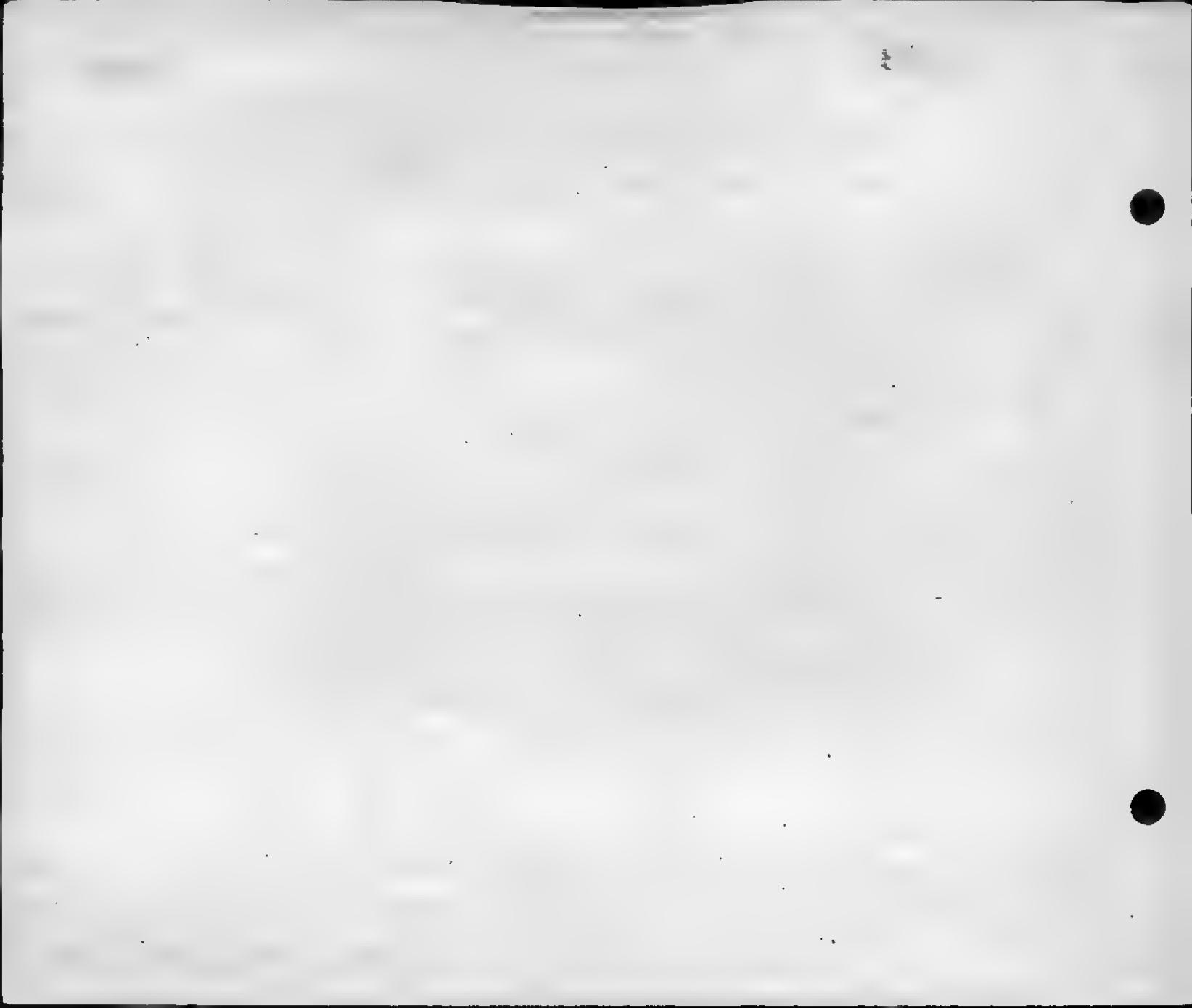
## CERTIFICATE OF DEATH

08549

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

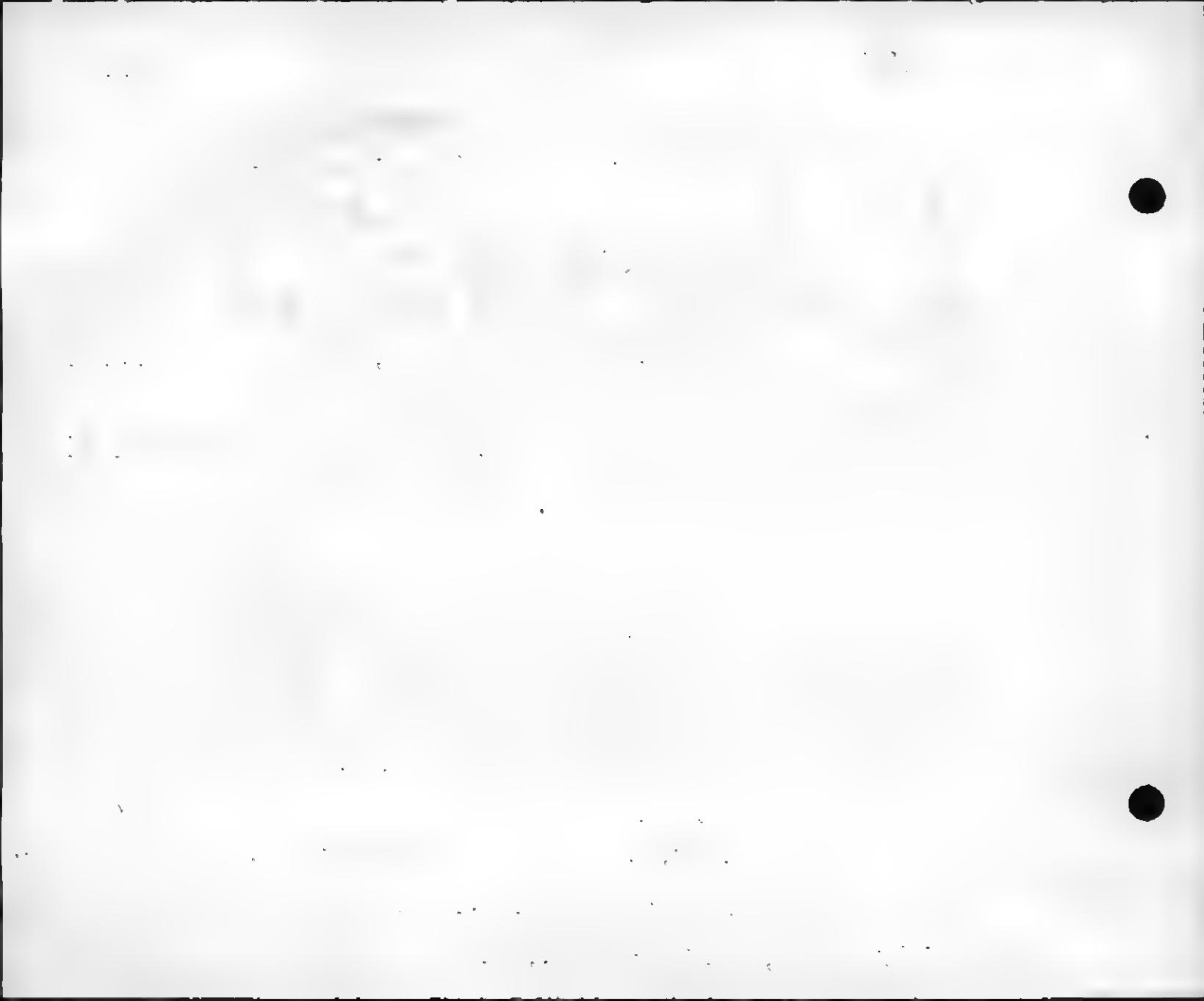
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Montgomery		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 9 MONTH	
Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Carroll Hall Somers, New York		12906 Estelle Road	
3. NAME OF DECEASED (Type or print)		First	Middle
HESTER MAY Best			Last
4. SEX		5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	B. DATE OF BIRTH MARCH 24, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		At Home	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
At Home Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Earp		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		578-20-5373	
17. INFORMANT		Address	
MERRIS BEST-12906 ESTELLE RD.		UPTON, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. — p.m. —		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work <input type="checkbox"/> at work <input type="checkbox"/>
20f. (City or town)		(County)	
		(State)	
21. I certify that (1) (this hospital) attended the deceased from ..... 6/26, 1966, to ..... present, 19....., that (1) (we) last saw the deceased alive on ..... 6/26, 1966, and that death occurred at 55 M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
John B. Clark		6/26/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
John B. Clark		8805 Conn. Ave., Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		6/29/1966	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)	
Cedar Hill Cemetery		Santana, Md.	
(State)			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
W. H. CHAMBERS, INC. Silver Spring, Md.		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE	
		DATE JUL 1 1966 J. Charles Judge	



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CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE																			
MONTGOMERY MARYLAND				MARYLAND																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b																			
SILVER SPRING				2 days																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS																			
HOLY CROSS				518 DARTMOUTH AVE																			
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year													
Lucille Francis Billings							6	21	1966														
5. SEX				6. COLOR OR RACE		7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH				9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.							
Female				White		<input checked="" type="checkbox"/>	<input type="checkbox"/>	10-12-07				58 yrs.		Months		Days	Hours	Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?													
Housewife				Own Home		Marietta, Ohio				U. S. A.													
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME																			
Cecil Pemberton				Unknown																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address											
No None				None				Samuel Clark Billings Silver Spring, Md.				518 Dartmouth Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a)				Coronary thrombosis								INTERVAL BETWEEN ONSET AND DEATH											
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				3 days								?											
(b)				Atherosclerosis																			
(c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																							
Diseas mellitus																							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1966 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)	(State)								
21. I certify that (I) (this hospital) attended the deceased from <u>6/6/66</u> to <u>6/6/66</u> , 1966, that (I) (we) last saw the deceased alive on <u>6/20/66</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.												22b. DATE SIGNED <u>6/21/66</u>											
22a. SIGNATURE <u>William D. Aud</u>				22b. DATE SIGNED <u>6/21/66</u>								22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>											
22c. PHYSICIAN'S NAME (Type) <u>William D. Aud, M.D.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								23b. DATE THEREOF <u>June 24, 1966</u>				23c. NAME OF CEMETERY OR CREMATORIUM <u>George Wash. Mem. Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Hyattsville, Maryland</u>			
24. FUNERAL DIRECTOR <u>John E. Thomas</u>				ADDRESS <u>8434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Md.</u>								25a. REC'D BY REGISTRAR <u>JUN 24 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							
VR A15 (4) 20M 1/65																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

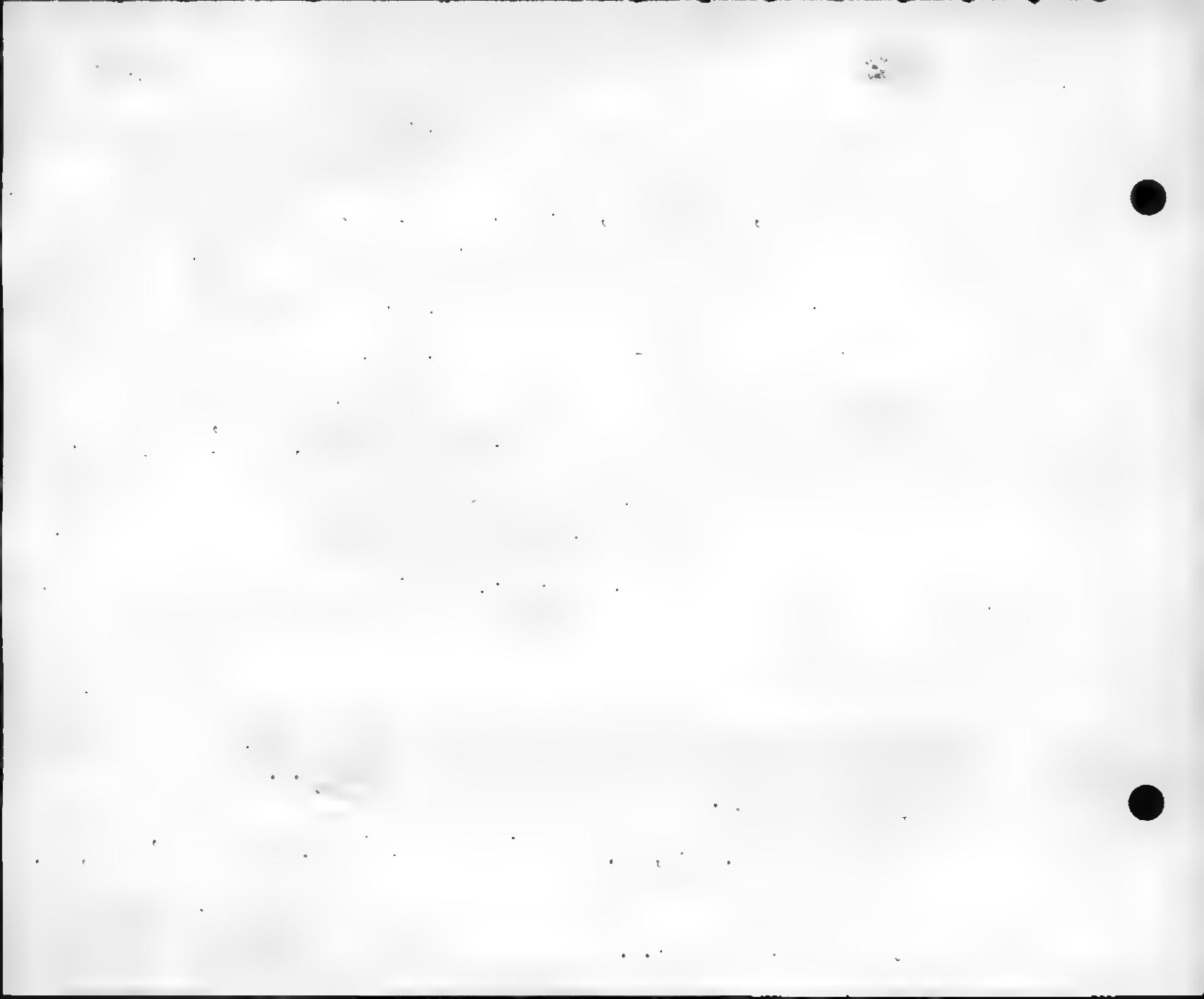
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

1 M 08561 08551

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>29 Days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <b>Maryland</b>		b. COUNTY <b>Kent County</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>		d. STREET ADDRESS <b>Route #2, Box 209</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>Robert</b>	Middle <b>Franklin</b>	Last <b>Black</b>	4. DATE OF DEATH Month <b>June</b>	Day <b>2</b>	Year <b>1966</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>18 July 1951</b>	9. AGE (In years last birthday) <b>14 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Daniel Black</b>				14. MOTHER'S MAIDEN NAME <b>Anna Johnson</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b>		18. ADDRESS <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right (Heart) ventricular failure</b>								6 Hours			
404.4 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) <b>Hypoxia due to respiratory insufficiency</b>				6 Hours			
				DUE TO (c) <b>Severe Pulmonary Hypertension</b>				18 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4 May</b> , 19 <b>66</b> , to <b>2 June</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2 June</b> , 19 <b>66</b> , and that death occurred at <b>12:30</b> AM, for the causes and on the date stated above.						22b. DATE SIGNED <b>2 June 1966</b>					
22a. SIGNATURE <i>Robert L. Reis</i>		M.O. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <b>Robert L. Reis, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6/3/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>---</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Maryland</b>					
24. FUNERAL DIRECTOR <b>FRAZIERS FUNERAL HOME</b>		ADDRESS <b>D.C.</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
DATE											



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

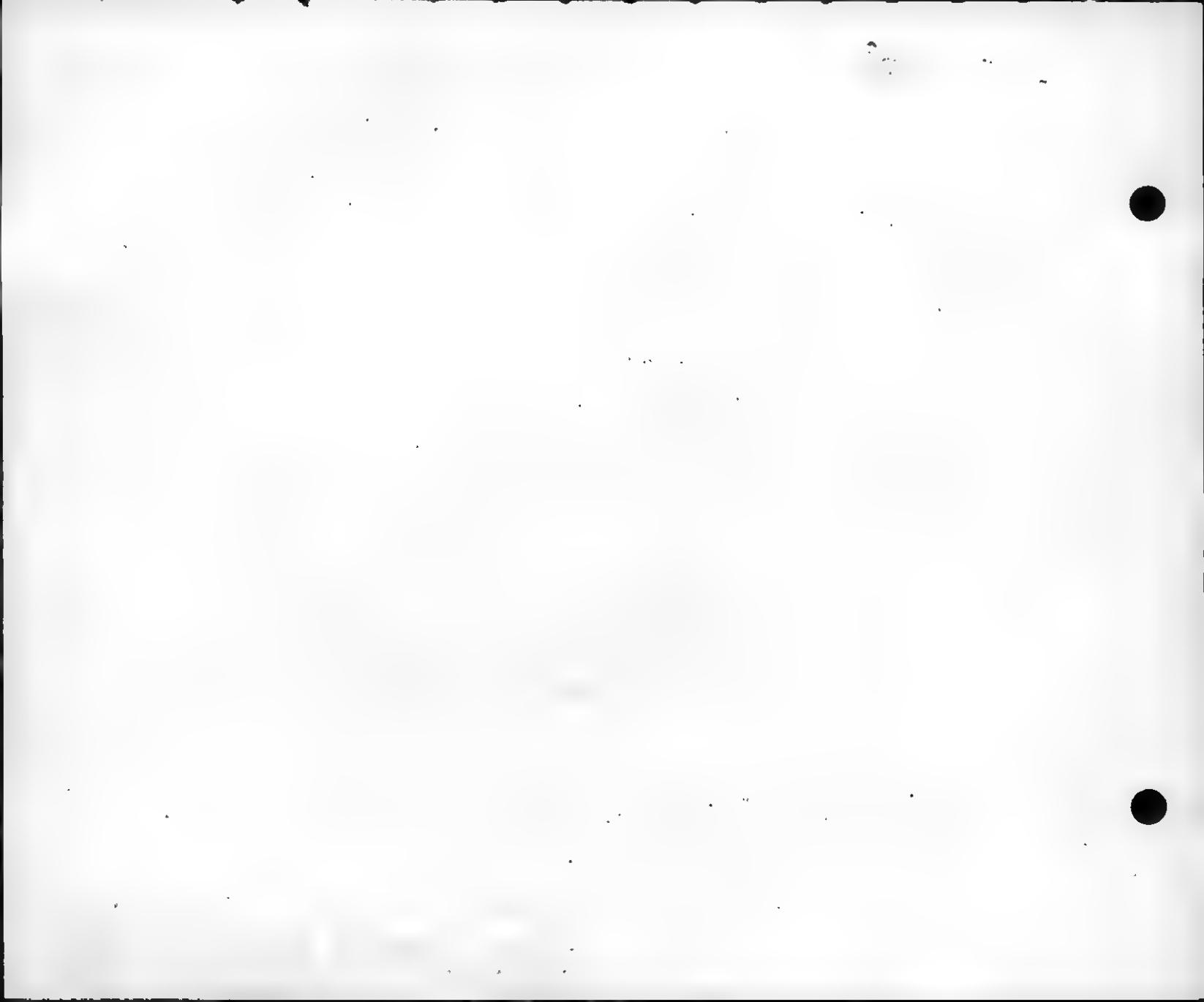
## CERTIFICATE OF DEATH

116552

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>5708 Toussig Rd</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month Day Year <b>June 10 1966</b>	
3. NAME OF DECEASED (Type or print) <b>Joseph Raymond Blisard</b>		First <b>Joseph</b>	Middle <b>Raymond</b>
4. DATE OF DEATH Month Day Year <b>June 10 1966</b>		Last <b>Blisard</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>June 9, 1966</b>		9. AGE (in years last birthday) yrs. <b>12</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>12 32</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>		13. FATHER'S NAME <b>Raymond John Blisard</b>	
14. MOTHER'S MAIDEN NAME <b>Eileen Veronica O'Neill</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Due to Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)  Due to (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1000 Lebanon St, 55 M</b>
20f. (City or town) <b>6/9</b>		(County) (State) <b>1966</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6/9</b> , 1966, to <b>6/9</b> , 1966, that (I) (we) last saw the deceased alive on <b>6/9</b> , 1966, and that death occurred at <b>6A</b> M, from the causes and on the date stated above.		22b. DATE SIGNED <b>6/10/66</b>	
22a. SIGNATURE <b>Salvatore Battista</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>1000 Lebanon St, 55 M</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/11/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>
23d. LOCATION (City, town or county) <b>Silver Spring, Md.</b>		(State)	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>JUN 15 1966</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove can on pages 1 and 2. If you are unable to do this, attach page 3 to the back of this certificate and return it to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



1. M  
FOR STATE  
HEALTH DEPT.

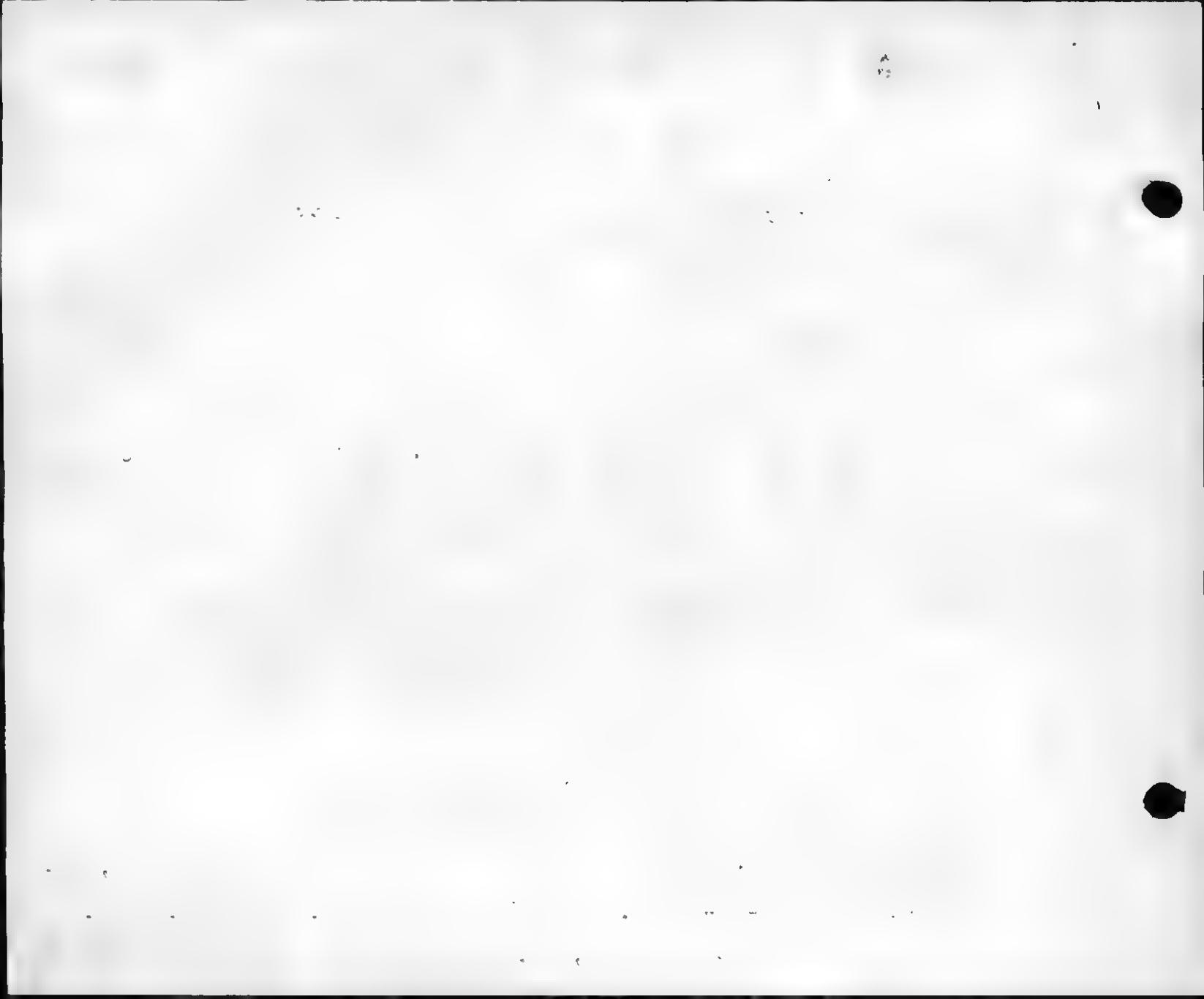
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, written the word "Pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08563		08553	
<p>1. PLACE OF DEATH a. COUNTY <i>Montgomery</i></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington.</i></p> <p>c. LENGTH OF STAY IN 1b <i>D.O.A</i></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4501 Dresden St.</i></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i></p> <p>d. STREET ADDRESS <i>4501 Dresden Street.</i></p>	
<p>3. NAME OF DECEASED (Type or print) <i>STEPHEN</i></p> <p>First <i>JOSEPH</i> Middle <i>BORRE</i> Last <i>BORRE</i></p>		<p>4. DATE OF DEATH <i>June 25 1966.</i></p>	
<p>5. SEX <i>M.</i> 6. COLOR OR RACE <i>W.</i></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>11/9/46.</i></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accounting Clerk</i></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <i>?</i></p>	
<p>11. BIRTHPLACE (State or foreign country) <i>California.</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>Louis J. Borre.</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Noemie. Feroglio</i></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>Unknown</i></p>	
<p>17. INFORMANT <i>Louis J. Borre</i></p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <i>Pulmonary Edema Acute</i></p>	
<p>DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Foreign Body - Rubber band</i></p>		<p>DUE TO (c) <i>Rt main bronchus. 2 hr.</i></p>	
<p>INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>accidently inhaled a rubber band</i></p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour, a.m. <i>12:00 p.m. 6/25 1966</i></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i></p>		<p>20f. (City or town) (County) (State) <i>Kensington Mont. Md</i></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>			
<p>22. DATE SIGNED <i>6/25/66</i></p>			
<p>MEDICAL CERTIFICATION ACTUAL SIGNATURE <i>John G. Ball</i></p>		<p>EXAMINER'S NAME (Type) <i>JOHN G. BALL</i></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit</i></p>		<p>23b. DATE THEREOF <i>6-25-66</i></p>	
<p>23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Joseph's Cemetery</i></p>		<p>23d. LOCATION (City, town or county) (State) <i>W. Roxberry, Mass.</i></p>	
<p>24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Md.</i></p>		<p>25a. REC'D BY REGISTRAR <i>JUN 29 1966</i></p>	
<p>ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Md.</i></p>		<p>25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i></p>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

108554

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rockville

MARYLAND

c. LENGTH OF STAY IN lb

3- Month

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Belmont Nursing Home

3. NAME OF DECEASED

(Type or print)

Grace Bess

First

Middle

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

a. STATE

b. COUNTY

Maryland

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Burtonsville

d. STREET ADDRESS

e. IS RESIDENCE

ON A FARM?

YES  NO 

Year

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

11. BIRTHPLACE (County &amp; State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which  
gave rise to immediate cause

{ (b)

IMMEDIATE CAUSE (c)

Causes, if any, which  
gave rise to immediate cause

{ (d)

IMMEDIATE CAUSE (e)

Causes, if any, which  
gave rise to immediate cause

{ (f)

IMMEDIATE CAUSE (g)

Causes, if any, which  
gave rise to immediate cause

{ (h)

IMMEDIATE CAUSE (i)

Causes, if any, which  
gave rise to immediate cause

{ (j)

IMMEDIATE CAUSE (k)

Causes, if any, which  
gave rise to immediate cause

{ (l)

IMMEDIATE CAUSE (m)

Causes, if any, which  
gave rise to immediate cause

{ (n)

IMMEDIATE CAUSE (o)

Causes, if any, which  
gave rise to immediate cause

{ (p)

IMMEDIATE CAUSE (q)

Causes, if any, which  
gave rise to immediate cause

{ (r)

IMMEDIATE CAUSE (s)

Causes, if any, which  
gave rise to immediate cause

{ (t)

IMMEDIATE CAUSE (u)

Causes, if any, which  
gave rise to immediate cause

{ (v)

IMMEDIATE CAUSE (w)

Causes, if any, which  
gave rise to immediate cause

{ (x)

IMMEDIATE CAUSE (y)

Causes, if any, which  
gave rise to immediate cause

{ (z)

IMMEDIATE CAUSE (aa)

Causes, if any, which  
gave rise to immediate cause

{ (bb)

IMMEDIATE CAUSE (cc)

Causes, if any, which  
gave rise to immediate cause

{ (dd)

IMMEDIATE CAUSE (ee)

Causes, if any, which  
gave rise to immediate cause

{ (ff)

IMMEDIATE CAUSE (gg)

Causes, if any, which  
gave rise to immediate cause

{ (hh)

IMMEDIATE CAUSE (ii)

Causes, if any, which  
gave rise to immediate cause

{ (jj)

IMMEDIATE CAUSE (kk)

Causes, if any, which  
gave rise to immediate cause

{ (ll)

IMMEDIATE CAUSE (mm)

Causes, if any, which  
gave rise to immediate cause

{ (nn)

IMMEDIATE CAUSE (oo)

Causes, if any, which  
gave rise to immediate cause

{ (oo)

IMMEDIATE CAUSE (pp)

Causes, if any, which  
gave rise to immediate cause

{ (pp)

IMMEDIATE CAUSE (qq)

Causes, if any, which  
gave rise to immediate cause

{ (qq)

IMMEDIATE CAUSE (rr)

Causes, if any, which  
gave rise to immediate cause

{ (rr)

IMMEDIATE CAUSE (ss)

Causes, if any, which  
gave rise to immediate cause

{ (ss)

IMMEDIATE CAUSE (tt)

Causes, if any, which  
gave rise to immediate cause

{ (tt)

IMMEDIATE CAUSE (uu)

Causes, if any, which  
gave rise to immediate cause

{ (uu)

IMMEDIATE CAUSE (vv)

Causes, if any, which  
gave rise to immediate cause

{ (vv)

IMMEDIATE CAUSE (ww)

Causes, if any, which  
gave rise to immediate cause

{ (ww)

IMMEDIATE CAUSE (xx)

Causes, if any, which  
gave rise to immediate cause

{ (xx)

IMMEDIATE CAUSE (yy)

Causes, if any, which  
gave rise to immediate cause

{ (yy)

IMMEDIATE CAUSE (zz)

Causes, if any, which  
gave rise to immediate cause

{ (zz)

IMMEDIATE CAUSE (aa)

Causes, if any, which  
gave rise to immediate cause

{ (aa)

IMMEDIATE CAUSE (bb)

Causes, if any, which  
gave rise to immediate cause

{ (bb)

IMMEDIATE CAUSE (cc)

Causes, if any, which  
gave rise to immediate cause

{ (cc)

IMMEDIATE CAUSE (dd)

Causes, if any, which  
gave rise to immediate cause

{ (dd)

IMMEDIATE CAUSE (ee)

Causes, if any, which  
gave rise to immediate cause

{ (ee)

IMMEDIATE CAUSE (ff)

Causes, if any, which  
gave rise to immediate cause

{ (ff)

IMMEDIATE CAUSE (gg)

Causes, if any, which  
gave rise to immediate cause

{ (gg)

IMMEDIATE CAUSE (hh)

Causes, if any, which  
gave rise to immediate cause

{ (hh)

IMMEDIATE CAUSE (ii)

Causes, if any, which  
gave rise to immediate cause

{ (ii)

IMMEDIATE CAUSE (jj)

Causes, if any, which  
gave rise to immediate cause

{ (jj)

IMMEDIATE CAUSE (kk)

Causes, if any, which  
gave rise to immediate cause

{ (kk)

IMMEDIATE CAUSE (ll)

Causes, if any, which  
gave rise to immediate cause

{ (ll)

IMMEDIATE CAUSE (mm)

Causes, if any, which  
gave rise to immediate cause

{ (mm)

IMMEDIATE CAUSE (nn)

Causes, if any, which  
gave rise to immediate cause

{ (nn)

IMMEDIATE CAUSE (oo)

Causes, if any, which  
gave rise to immediate cause

{ (oo)

IMMEDIATE CAUSE (pp)

Causes, if any, which  
gave rise to immediate cause

{ (pp)

IMMEDIATE CAUSE (qq)

Causes, if any, which  
gave rise to immediate cause

{ (qq)

IMMEDIATE CAUSE (rr)

Causes, if any, which  
gave rise to immediate cause

{ (rr)

IMMEDIATE CAUSE (ss)

Causes, if any, which  
gave rise to immediate cause

{ (ss)

IMMEDIATE CAUSE (tt)

Causes, if any, which  
gave rise to immediate cause

{ (tt)

IMMEDIATE CAUSE (uu)

Causes, if any, which  
gave rise to immediate cause

{ (uu)

IMMEDIATE CAUSE (vv)

Causes, if any, which  
gave rise to immediate cause

{ (vv)

IMMEDIATE CAUSE (ww)

Causes, if any, which  
gave rise to immediate cause

{ (ww)

IMMEDIATE CAUSE (xx)

Causes, if any, which  
gave rise to immediate cause

{ (xx)

IMMEDIATE CAUSE (yy)

Causes, if any, which  
gave rise to immediate cause

{ (yy)

IMMEDIATE CAUSE (zz)

Causes, if any, which  
gave rise to immediate cause

{ (zz)

IMMEDIATE CAUSE (aa)

Causes, if any, which  
gave rise to immediate cause

{ (aa)

IMMEDIATE CAUSE (bb)

Causes, if any, which  
gave rise to immediate cause

{ (bb)

IMMEDIATE CAUSE (cc)

Causes, if any, which  
gave rise to immediate cause

{ (cc)

IMMEDIATE CAUSE (dd)

Causes, if any, which  
gave rise to immediate cause19. WAS AUTOPSY PERFORMED? YES  NO 

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY  
Hour e.m. — 19  
p.m. —20d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20g. ATTENDING PHYS

20h. MED. DIRECTOR 20i. STAFF PHYS. 

22d. ADDRESS

23c. NAME OF CEMETERY OR CREMATORI

ADDRESS

Laurel, Md

23d. LOCATION (City, town or county)

(State)

Burtonsville, Md.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Charles Judge

JUN 9 1966

Burtonsville, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial June 7, 1966

23f. FUNERAL DIRECTOR'S SIGNATURE

Burtonsville, Md.

23g. VR AIS (4)

15M 7 61



1  
FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08565

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08555

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN ID

52 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban

3. NAME OF  
DECEASED  
(Type or print)

First  
Willie

Middle  
C

Last  
Bou

4. DATE  
OF  
DEATH  
June 1 1966

e. IS RESIDENCE  
ON A FARM?  
YES  NO

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

1896  
9/30/1898

9. AGE (In years  
last birthday)

72 yrs.

10. KIND OF BUSINESS OR  
INDUSTRY

Months  
8

IF UNDER 1 YEAR  
Days  
1

IF UNDER 24 HRS.  
Hours  
19  
Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Newark, N.J.

12. CITIZEN OF WHAT  
COUNTRY?

USA

13. FATHER'S NAME

Willie

Bou

14. MOTHER'S MAIDEN NAME

2

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

145031474

Address  
Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Coronary Insufficiency Acute -

INTERVAL BETWEEN  
ONSET AND DEATH

1 hr.

4301

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

Cardio-Vascular Disease -

4 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion

death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

John G. Ball -

EXAMINER'S  
NAME (Type)

JOHN G. BALL

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Bethesda, Md.

22. DATE SIGNED

6/1/66

Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

Burial-Transit 6-2-66 Franklin Memorial Park New Brunswick, N.J. Jersey

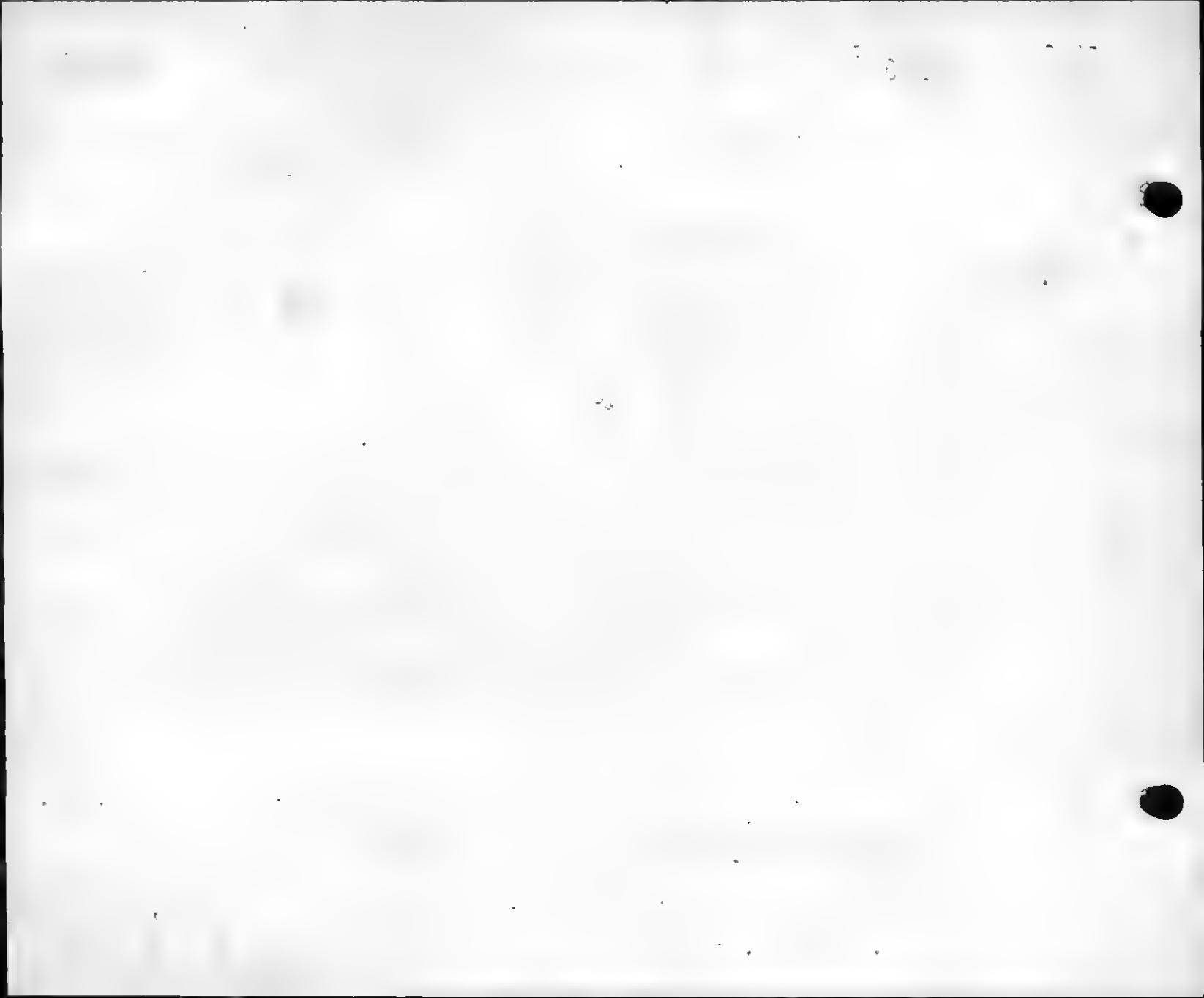
24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

ROBERT A. PUMPHREY, Bethesda, Maryland DATE JUN 6 1966 Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VR A15ME  
350D 4-64



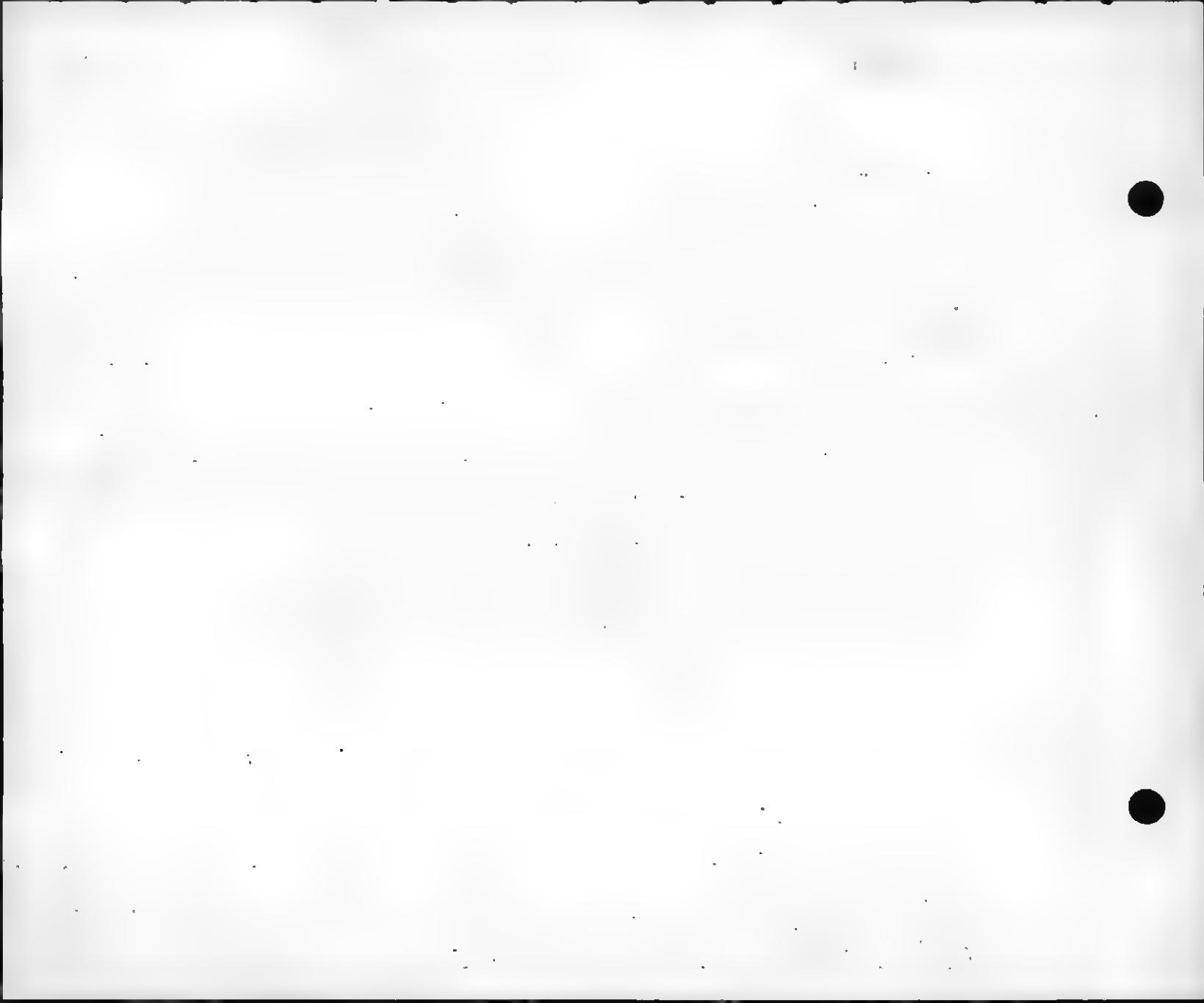
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

03566 08556

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>509 East Schuyler Road</b>	
3. NAME OF DECEASED (Type or print) <b>John Samuel Boyer</b>		4. DATE OF DEATH <b>June 30 1966</b>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
6. SEX <b>Male</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1879</b>	9. AGE (In years last birthday) <b>86 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Capitol Transit</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Sharpsburg, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>William Henry Boyer</b>	14. MOTHER'S MAIDEN NAME <b>Martha M. Mose</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>578-10-6184</b>	17. INFORMANT <b>Leo W. Boyer</b>	Address <b>509 East Schuyler Road Silver Spring, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>Arteriosclerosis</b>		?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>30 June 1966</b> , that (I) (we) last saw the deceased alive on <b>30 June 1966</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William D. And</b>		22b. DATE SIGNED <b>6/30/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William D. And</b>	22d. ADDRESS <b>9006 Colesville Rd., Silver Spring, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 5, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Lincoln Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Prince Georges Co., Md.</b>
24. FUNERAL DIRECTOR <b>Glen Carter C. Elton Carter</b>	25a. ADDRESS <b>8434 Georgia Ave.</b>	25b. REC'D BY REGISTRAR <b>DATE JUL 6 1986</b>	25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

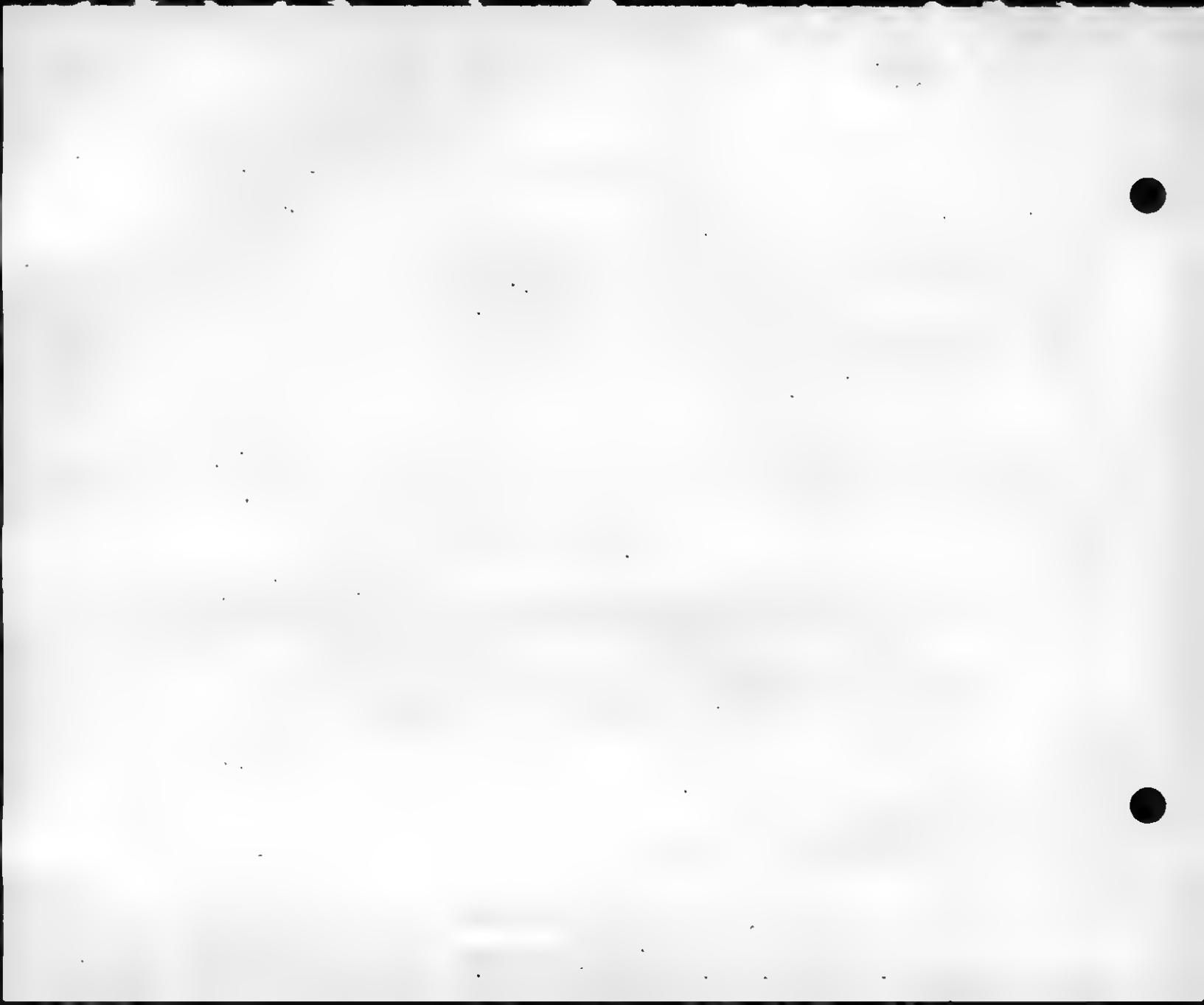
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08561

Item 1 Item 277 by 16/66 mh  
CERTIFICATE OF DEATH

118557

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	c. LENGTH OF STAY IN 1b 2 Mo. 131 Days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. &amp; Hosp.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Katherine Louise Brady</i>	4. DATE OF DEATH Month Day Year June 6 1966				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-1-1918</i>	9. AGE (in years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Statistical Clerk</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Labor Dept</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Md., Washington, D.C. U.S.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Md., Washington, D.C. U.S.</i>		
13. FATHER'S NAME <i>Murphy Brady</i>	14. MOTHER'S MAIDEN NAME <i>Chambers, Hazelton Belle</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Stanley Hurwitz # 3 Hilltop Road Silver Spring, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial failure</i>					
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.	1. DUE TO (b) <i>metastatic carcinoma</i>	2. DUE TO (c) <i>carcinoma of breast (operated)</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>OCT 1966</i>	(County) <i>to JUNE 6, 1966</i>	(State) <i>that (I) (we) last saw the deceased alive on JUNE 6, 1966, and that death occurred at 8 AM, from the causes and on the date stated above.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>OCT 1966</i> to <i>JUNE 6, 1966</i> , that (I) (we) last saw the deceased alive on <i>JUNE 6, 1966</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.	22d. DATE SIGNED <i>JUNE 6 1966</i>				
22a. SIGNATURE <i>Robert L. Krichmar</i>	M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <i>Robert L. Krichmar MD</i>	22d. ADDRESS <i>3703 Alaska Avenue NW Washington D.C. 20012</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>June 8, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>National Memorial Park</i>	23d. LOCATION (City, town or county) <i>Falls Church, Virginia</i>		
24. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc. Silver Spring, Md.</i>	ADDRESS <i>Glen Cliffs 8434 Georgia Avenue</i>	25a. REC'D BY REGISTRAR <i>JUN 13 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



5  
14  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

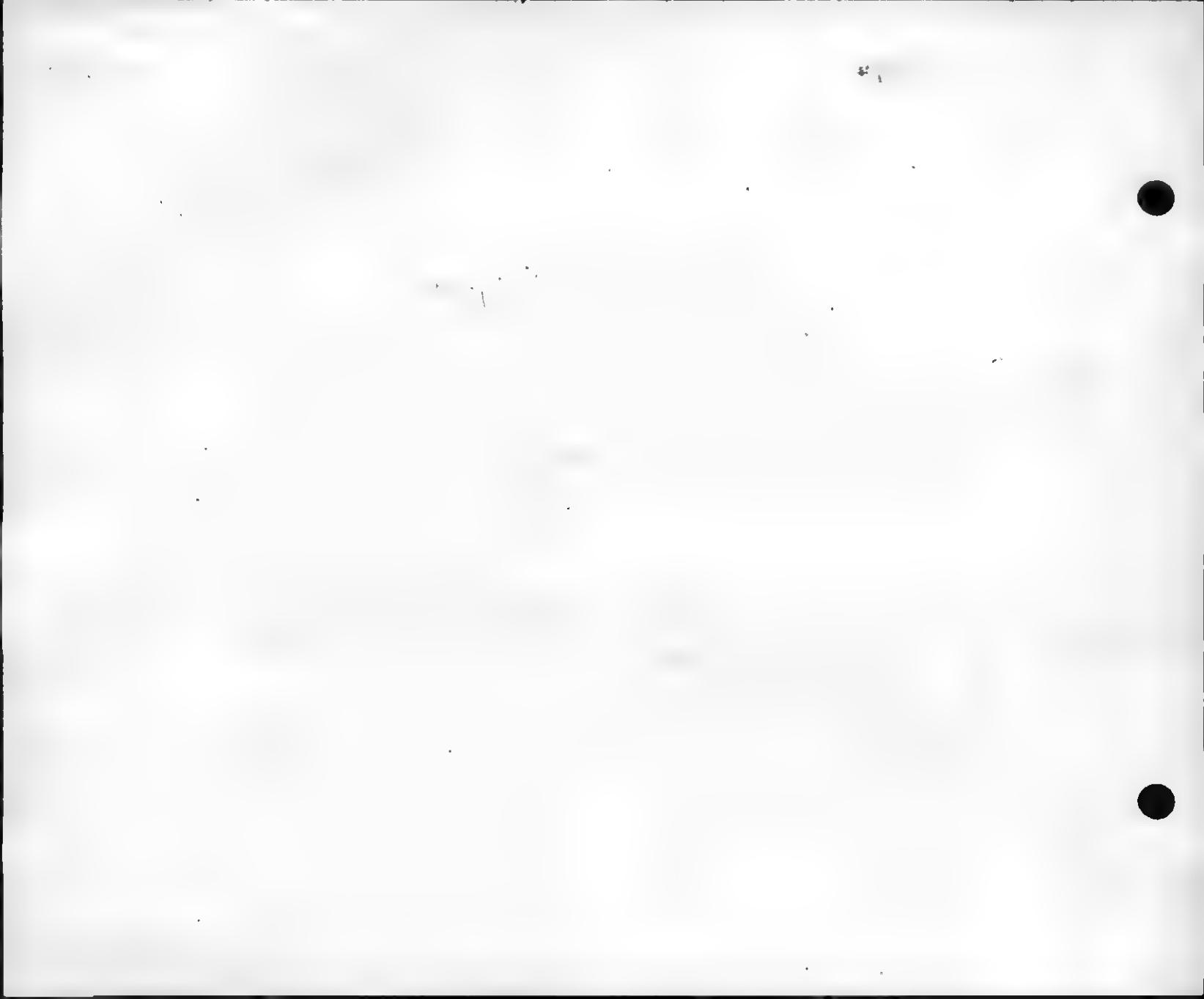
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #2c&d & 7 File #3328177 PC

CERTIFICATE OF DEATH

08568-118558

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bevinsda</i> LENGTH OF STAY IN TB <i>9 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suburban</i> <i>Exterior</i> <i>Bethesda</i> <i>Towson, Pa.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>758 Fairview Ave.</i> e. IS RESIDENCE ON A FARM? <i>4108 Maryland Ave.</i> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Edward</i>	Middle <i>George</i>	Last <i>Beanchik</i> 4. DATE OF DEATH Month <i>6</i> Day <i>11</i> Year <i>1966</i>
S. SEX <i>m.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <i>36</i>	8. DATE OF BIRTH <i>10-14-25</i> 9. AGE (in years last birthday) YRS <i>40</i> IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cartographer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i> 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>Michael Beanchik</i>		14. MOTHER'S MAIDEN NAME <i>Anna Ezerik</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <i>U.S.A. 1961</i>		16. SOCIAL SECURITY NO <i>206-18-1164</i>	17. INFORMANT <i>Frances - Wife</i> Address <i>758 Fairview Takoma Park, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant lymphoma, ex. lung</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <i>6/3</i> 20f. (City or town) <i>6/10</i> (County) <i>1966</i> (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6/9</i> to <i>6/10</i> , 1966, and that death occurred at <i>6/10</i> M, from causes and on the date stated above.		22b. DATE SIGNED <i>June 11, 1966</i>	
22c. SIGNATURE <i>George H. Mitchell</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>11125 Rockville Pike, Rockville, Md.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11 June 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem.</i> 23d. LOCATION (City or Town) <i>Arlington, Va.</i> (County) <i>1966</i> (State)
24. FUNERAL DIRECTOR <i>Glen Colle 18434 Georgia Avenue</i>		25a. ADDRESS <i>Warren E. Purnfrey, Inc. Silver Spring, Md.</i>	25b. REC'D BY REGISTRAR DATE <i>JUN 16 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08569

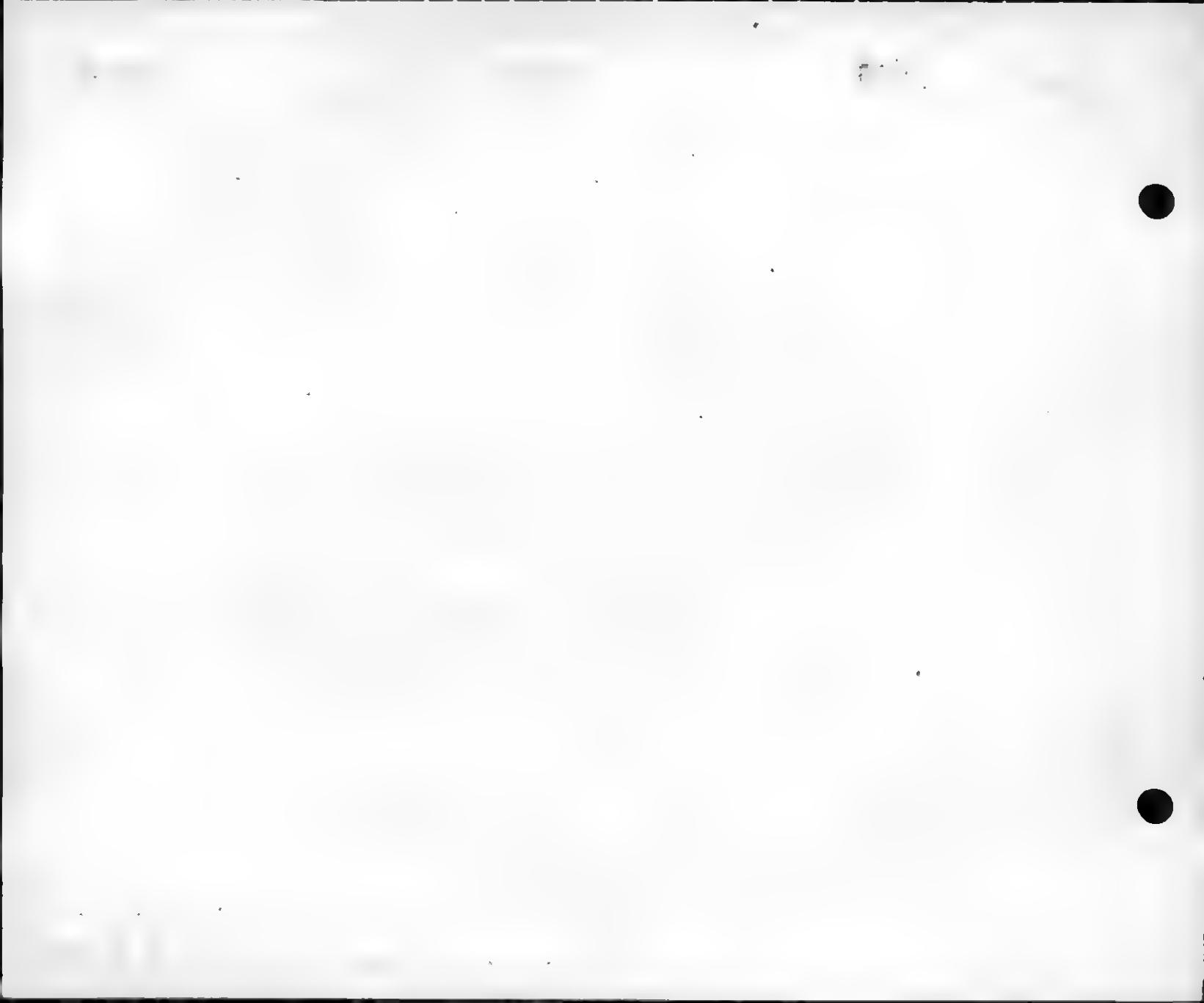
## CERTIFICATE OF DEATH

11559

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2, write RURAL and give nearest town)

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda</i>	<i>3 days</i>	<i>Washington</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Suburban</i>		<i>5031 8th St. N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Lilal</i>	Middle <i>H.</i>	Last <i>Brooks</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>8</i>	Year <i>1966</i>
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>F</i>	<i>Cal</i>		
8. DATE OF BIRTH	<i>Sept 22 1909</i>		
9. AGE (In years at death/birthday)	<i>11 yrs</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	
<i>none</i>		<i>Montgomery Co. Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?	<i>USA</i>		
13. FATHER'S NAME	14. MOTHER'S MARRIED NAME		
<i>William Hawkins</i>	<i>Jerry?</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
<i>No</i>			<i>Son. Warren Brooks (See above)</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Stremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause } last. (b) <i>Ischaemic arteriosclerosis</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>many years</i>			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral thrombosis, plethora melliaria</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Junes 1966 to June 8, 1966</i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
<i>19</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>June 7 1966</i> to <i>June 8, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 7 1966</i> , and that death occurred at <i>11:30 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>R. Hamm M.D.</i>		22b. DATE SIGNED <i>June 8, 1966</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town) (County) (State)
<i>Burial</i>	<i>6/11/66</i>	<i>Brooke Grove</i>	<i>Laytonsville, Md.</i>
24. FUNERAL DIRECTOR <i>Robert L. Smith</i>	ADDRESS <i>Rockville, Md.</i>	25a. REC'D BY REGISTRAR <i>JUN 14 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

08570

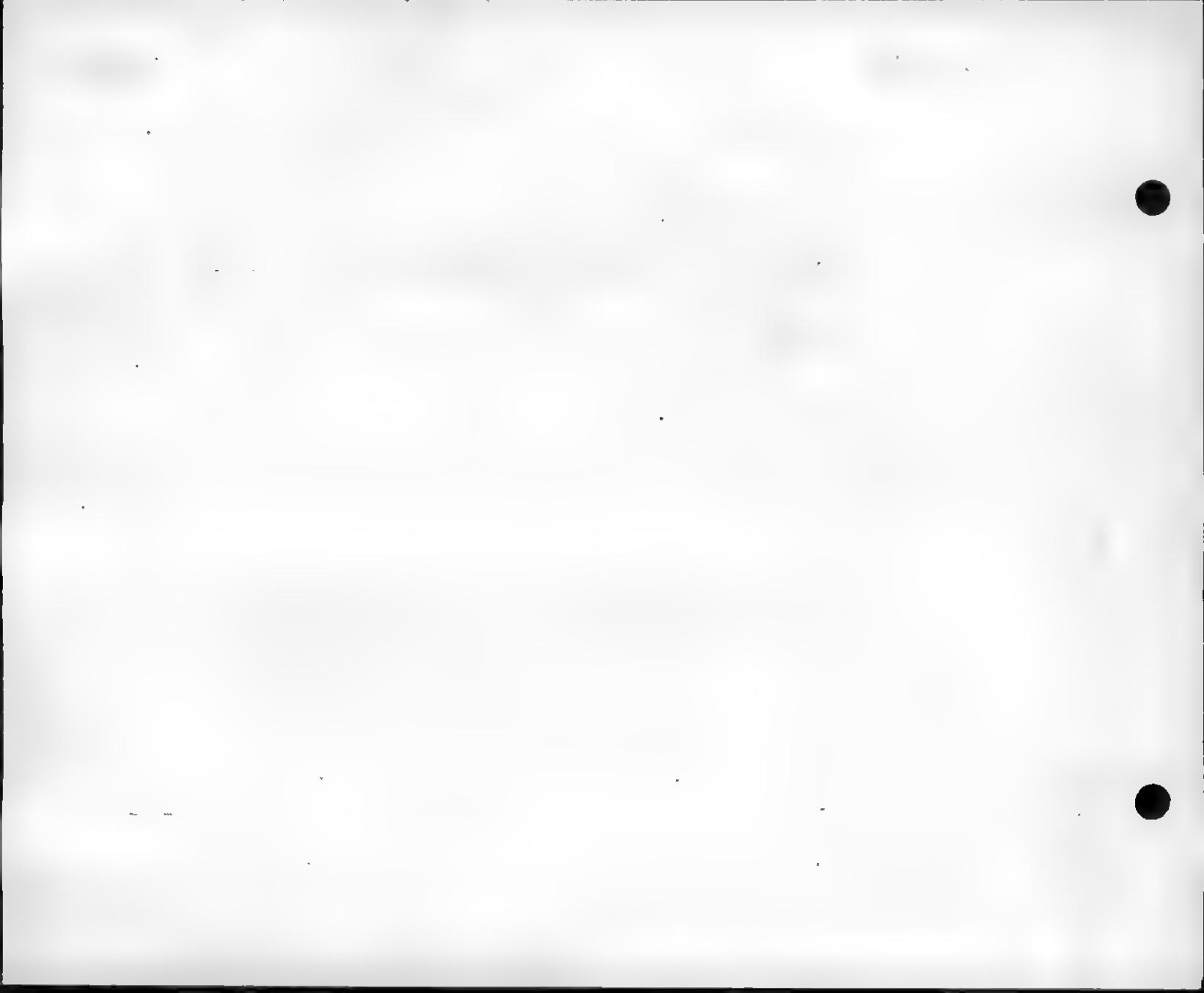
## CERTIFICATE OF DEATH

118560

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Howard</b>		First <b>Elgar</b>	Middle <b>Bryan</b>
4. DATE OF DEATH <b>6-29-66</b>	Month <b>6</b>	Day <b>29</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>5-5-12</b>		9. AGE (In years last birthday) <b>54 yrs.</b>	
10a. J.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Howard</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. MOTHER'S MAIDEN NAME <b>C. Bryan</b>		15. INFORMANT <b>Margaret Parsley</b>	
16. SOCIAL SECURITY NO.		Address	
17. INFORMANT <b>Hospital admission record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>5-6 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>6/13</i> , 19 <i>66</i> , to <i>6/25</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>6/13</i> 19 <i>66</i> , and that death occurred at <i>6 A.M.</i> from causes and on the date stated above		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>A. D. Bonifant</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M. D.</b>		22d. ADDRESS <b>Sandy Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-1-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Burial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Burtonsville Md.</b>	
24. FUNERAL DIRECTOR <i>John J. Bonifant</i>		25a. RECD BY REGISTRAR <b>JUL 7 1966</b>	
ADDRESS <i>J. Bonifant Funeral Home, Sandy Spring, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH REPS

TO DEPUTY  
please ex-  
4 should be  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tran-  
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08571

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08561

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Olney

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

Montgomery General Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

4-2-1924

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE, State or foreign country

9. AGE (In years  
last birthday)  
42 yrs.

IF UNDER 1 YEAR  
Months Days

IF UNDER 24 HRS.  
Hours Min.

13. FATHER'S NAME

Newton W. Budd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war or date of service)

17. INFORMANT

Franklin Budd, Brother, Celestine Armsted, Sister

Addison, Md. Lincoln Ave. 212

Rockville, Md.

INTERVAL BETWEEN  
ONSET AND DEATH

NO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY.  
IMMEDIATE CAUSE (a)

1124

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20c. TIME OF INJURY

Month, Day

Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, lot, etc.)

(City or town)

County

(State)

4:00 p.m. 6-19 66 While Not While   at work

20f. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 20e)

Deceased, pedestrian, struck by car  
on RTE. 97, 2 mi. North of Brookville, Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion

death resulted from: Natural causes  Accidental  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

22a. BURIAL, CREMATION  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/24/66

22c. NAME OF CEMETERY OR CREMATORIUM

Oak Grove Cemetery

ADDRESS

Rockville, Md.

22d. LOCATION

(City, town, or country)

DATE SIGNED

23. FUNERAL DIRECTOR

Robert L. Snowden

24a. REC'D BY REGISTRAR

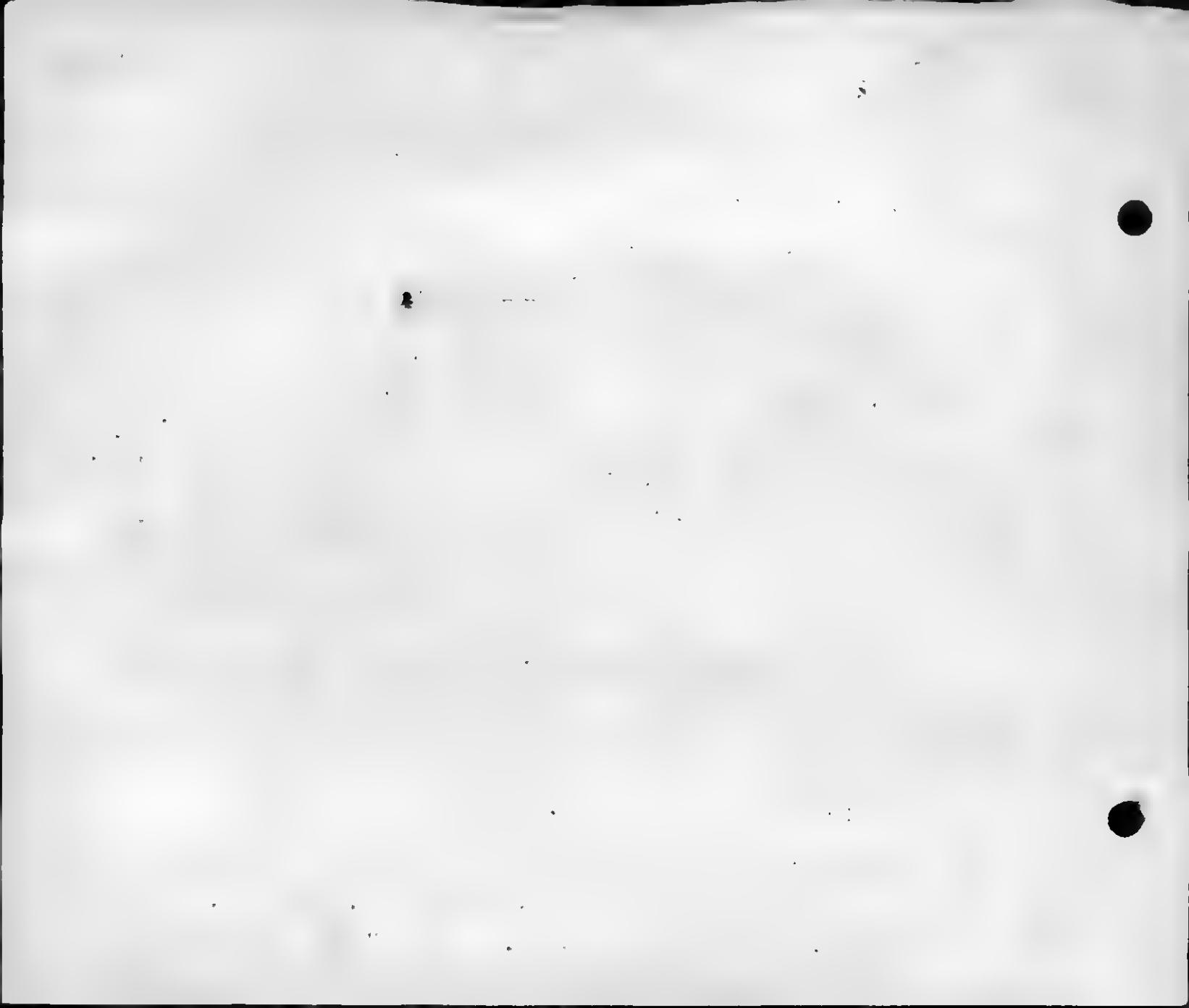
JUN 23 1966

24b. REGISTRAR'S SIGNATURE

Charles J. -

TO DEPUTY  
please ex-  
4 should be  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tran-  
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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38572

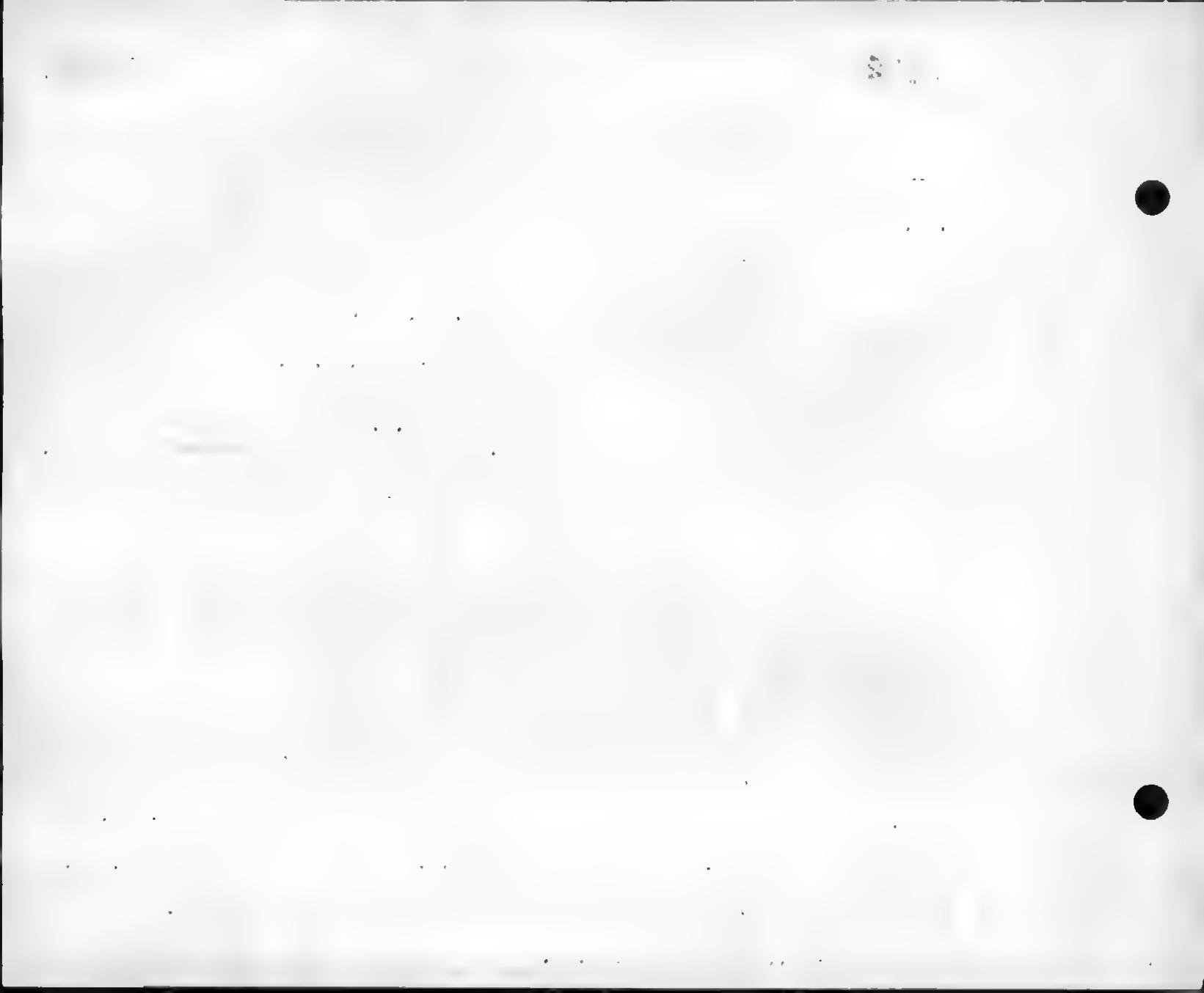
## CERTIFICATE OF DEATH

08562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN b <b>8 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
3. NAME OF DECEASED (Type or print) <b>Hattie</b>		First <b>Hattie</b>	Middle <b>Ball</b>		
4. DATE OF DEATH Month <b>June</b>	Day <b>1</b>	Year <b>19 66</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>		
8. DATE OF BIRTH <b>Feb. 14, 1884</b>	9. AGE (in years last birthday) <b>82 yrs</b>	10. KIND OF BUSINESS OR INDUSTRY <b>n/a</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Mottrom McAbe Ball</b>	14. MOTHER'S MAIDEN NAME <b>Priscilla Gantt</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>N.W. Washington</b> Address <b>DC</b> <b>Mrs. Margaret Fox, 1221 Massachusetts Ave.,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>PM</b> (County) <b>June 3, 1966</b> (State)	
21. I certify that <b>PM</b> (this hospital) attended the deceased from <b>May 24, 1966</b> , to <b>June 1, 1966</b> , that <b>PM</b> (we) last saw the deceased alive on <b>June 1, 1966</b> , and that death occurred at <b>1115 M</b> from causes and on the date stated above					
22a. SIGNATURE <b>Francis C. Johnson</b>		22b. DATE SIGNED <b>June 3, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>FRANCIS C. JOHNSON</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/6/1966</b>			
23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington, National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR Takoma Funeral Home ADDRESS <b>254 Carroll Ave., Takoma Park, D. C.</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1966</b>			
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08573

## CERTIFICATE OF DEATH

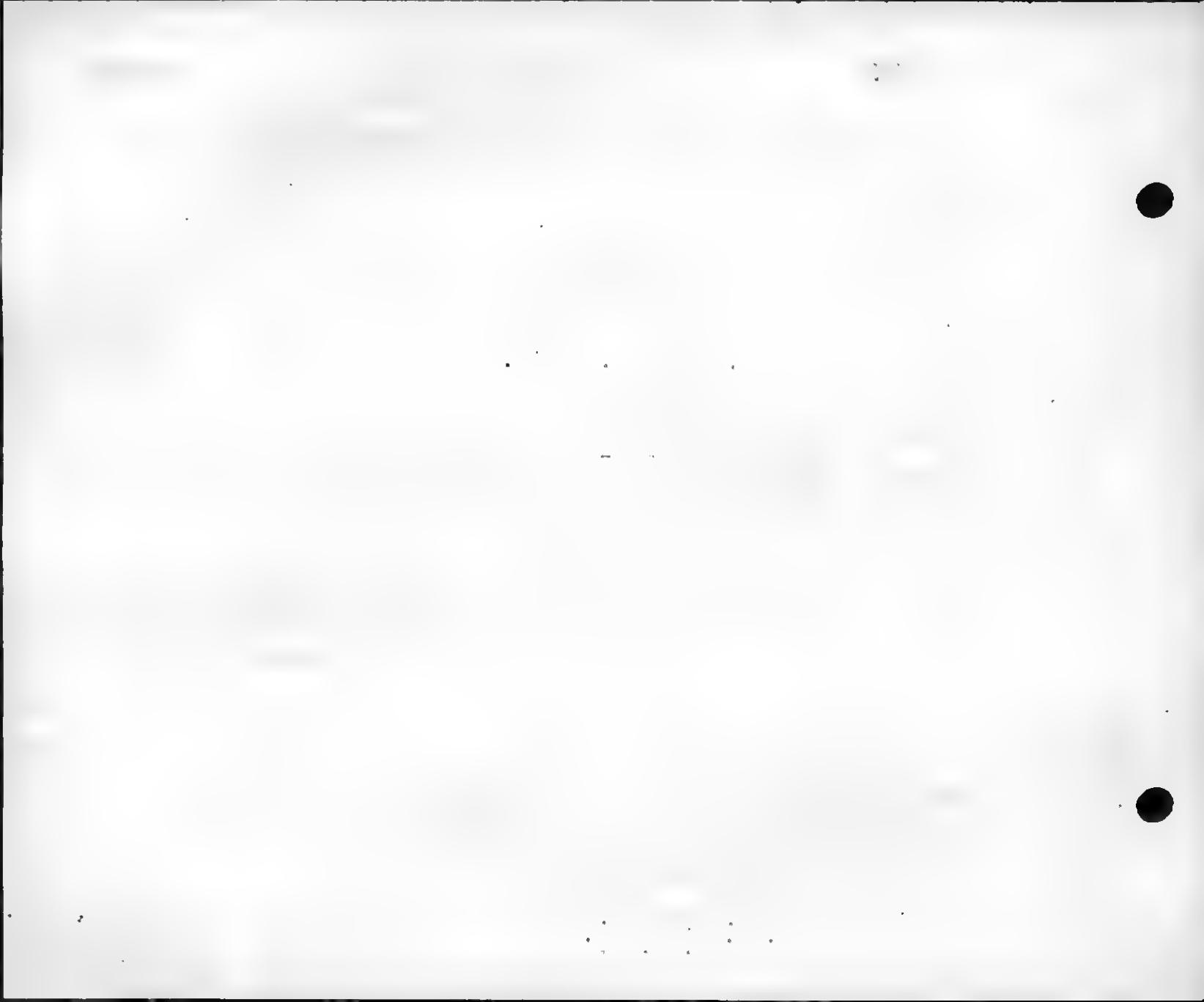
08563

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Washington, D.C.</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		d. STREET ADDRESS <i>4114 Legation St. N.W.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. + Hospital</i>				4. DATE OF DEATH <i>June 29</i>		Month	Year 1966
3. NAME OF DECEASED (Type or print) <i>Agnes</i>		First <i>Agnes</i>	Middle <i>NMN</i>	Last <i>Burkhalter</i>		Day	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>1-13-02</i>	9. AGE (In years lost birthday) <i>64 yrs.</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS Days <i>14</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - small Bus. Adm. U.S. Gov't.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Record - Washington San. + Hosp. Md</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>	
13. FATHER'S NAME <i>Charles Burkhalter</i>		14. MOTHER'S MAIDEN NAME <i>Maudie Shidmore</i>		Address <i>Takoma Park</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-24-4443</i>		17. INFORMANT <i>Record - Washington San. + Hosp. Md</i>		18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>44dx</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Cardiovascular disease</i>	
DUE TO (b) <i>Geriatric Enceph</i>		DUE TO (c) <i>Intersosseous + marked chest deform</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6/29/1966</i> to <i>6/29/1966</i> , that (I) (we) last saw the deceased alive on <i>6/29/1966</i> , and that death occurred at <i>4:30 P.M.</i> from causes and on the date stated above.							
22a. SIGNATURE <i>Chas H. Wolton</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-1-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Chas H. Wolton</i>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 1, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>	
24. FUNERAL DIRECTOR The S. H. Hines Washington, D. C.		25a. REC'D BY REGISTRAR DATE JUL 1 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

M

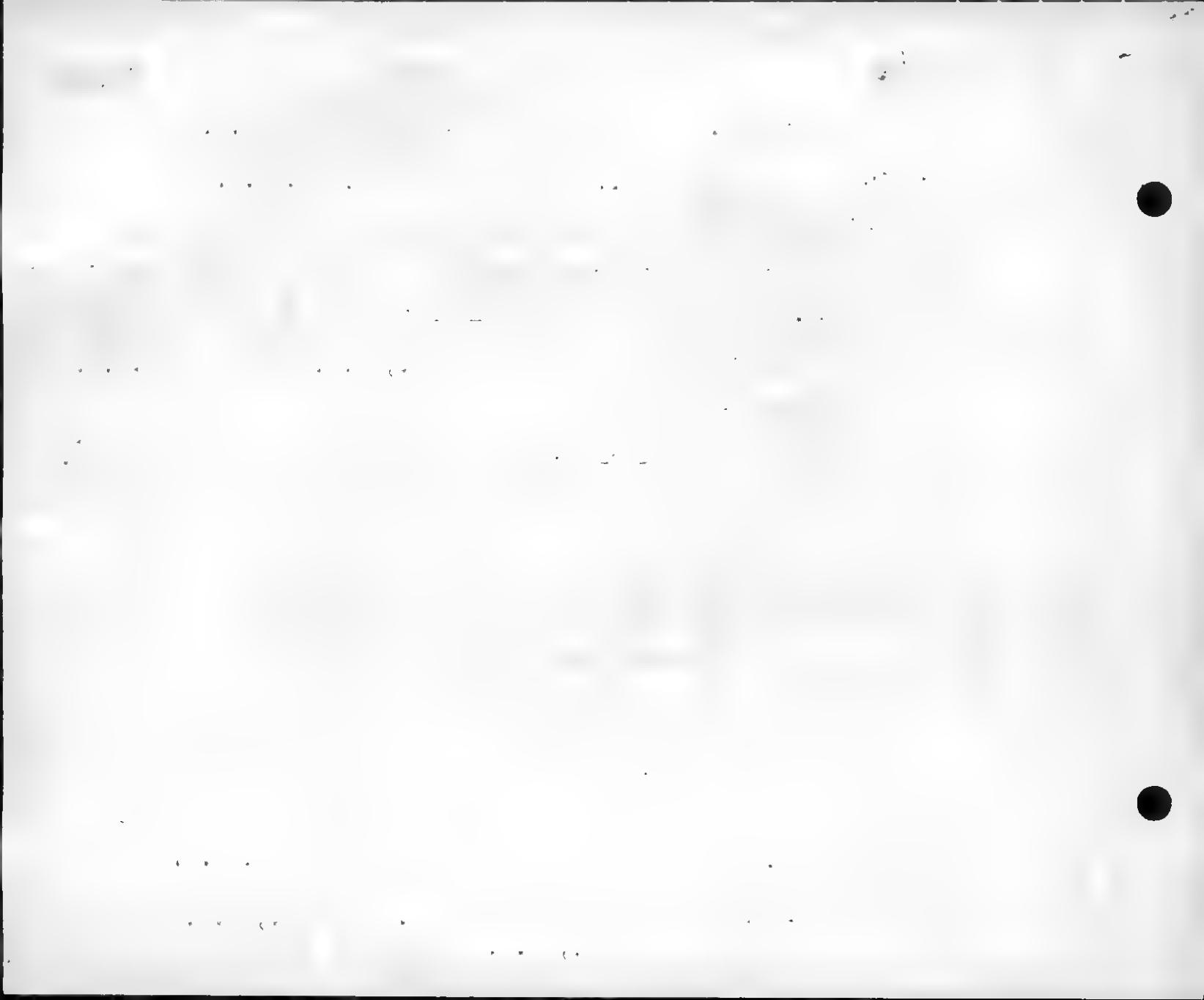
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08574

CERTIFICATE OF DEATH

08564

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY CO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASHINGTON D.C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>		c. LENGTH OF STAY IN lb <b>1mo. 1day</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNIVERSITY NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>EMMA</b>	Middle <b>WOODEND</b>	Last <b>BURNELL</b>	
4. DATE OF DEATH <b>JUNE 14 1966</b>	Month Day Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-27-1885</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FEDERAL GOVERNMENT</b>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min	
13. FATHER'S NAME <b>JOHN SMITH MURPHY</b>	14. MOTHER'S MAIDEN NAME <b>MARY WOODEN</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WASH. D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>579-60-8484</b>	17. INFORMANT <b>4504 DOLTON RD. DAUGHTER AND SON*CHEVY CHASE, MD.</b>	18. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)  5/10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  (c)		DUE TO  Hepatic Cirrhosis - Cirrhosis of Liver INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months plus		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>april 15, 1966</b> , to <b>June 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>June 14, 1966</b> , and that death occurred at <b>11:30 PM</b> , from causes and on the date stated above.				
22a. SIGNATURE <b>Neil P. Campbell</b>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>6/15/66</b>
22c. PHYSICIAN'S NAME (Type) <b>NEIL P. CAMPBELL</b>	22d. ADDRESS <b>1629 COLUMBIA RD. N.W.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6-17-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>CONGRESSIONAL CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>WASH. D.C.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS</b>	ADDRESS <b>WASH., D.C.</b>	25a. REC'D BY REGISTRAR <b>JUN 17 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08575

## CERTIFICATE OF DEATH

Reg. Dist. No.

08565

## PLACE OF DEATH

o. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

KENSINGTON

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION

10911 ORLEANS WAY

3. NAME OF  
DECEASED  
(Type or print)

First FRANCIS Middle XAVIER

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)

o. STATE

MARYLAND

b. COUNTY

MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

KENSINGTON

d. STREET ADDRESS

10911 ORLEANS WAY

e. IS RESIDENCE  
ON A FARM?  
YES  NO 

4. SEX

MALE

6. COLOR OR RACE

CAUCASIAN

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 4. DATE  
OF  
DEATH

Month 6

Day 17 Year 1966

8. DATE OF BIRTH

3/5/1919

9. AGE (In years  
last birthday)  
47 yrs10. IF UNDER 1 YEAR  
Months 0 Days 0 Hours 0 Min. 010a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

PERSONNEL MANAGER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN WISE BYRNES

14. MOTHER'S MAIDEN NAME

MARY C. HOLOHAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

YES

(If yes, give war or dates of service)

WWII

16. SOCIAL SECURITY NO.

-

INFORMANT

MRS. ANNE F. BYRNES, WIFE SAME AS #2 ABOVE Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH  
IMMEDIATE.

Acute CORONARY INSUFFICIENCY

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 17, 1966, to June 17, 1966, that I last saw the deceased  
alive on June 17, 1966, and that death occurred at 2:30 A.M. from the causes and on the date stated above.ACTUAL  
SIGNATURE

ADDRESS (Street, city or town, state) 817 UNIVERSITY BLVD E. DATE SIGNED 6-17-66

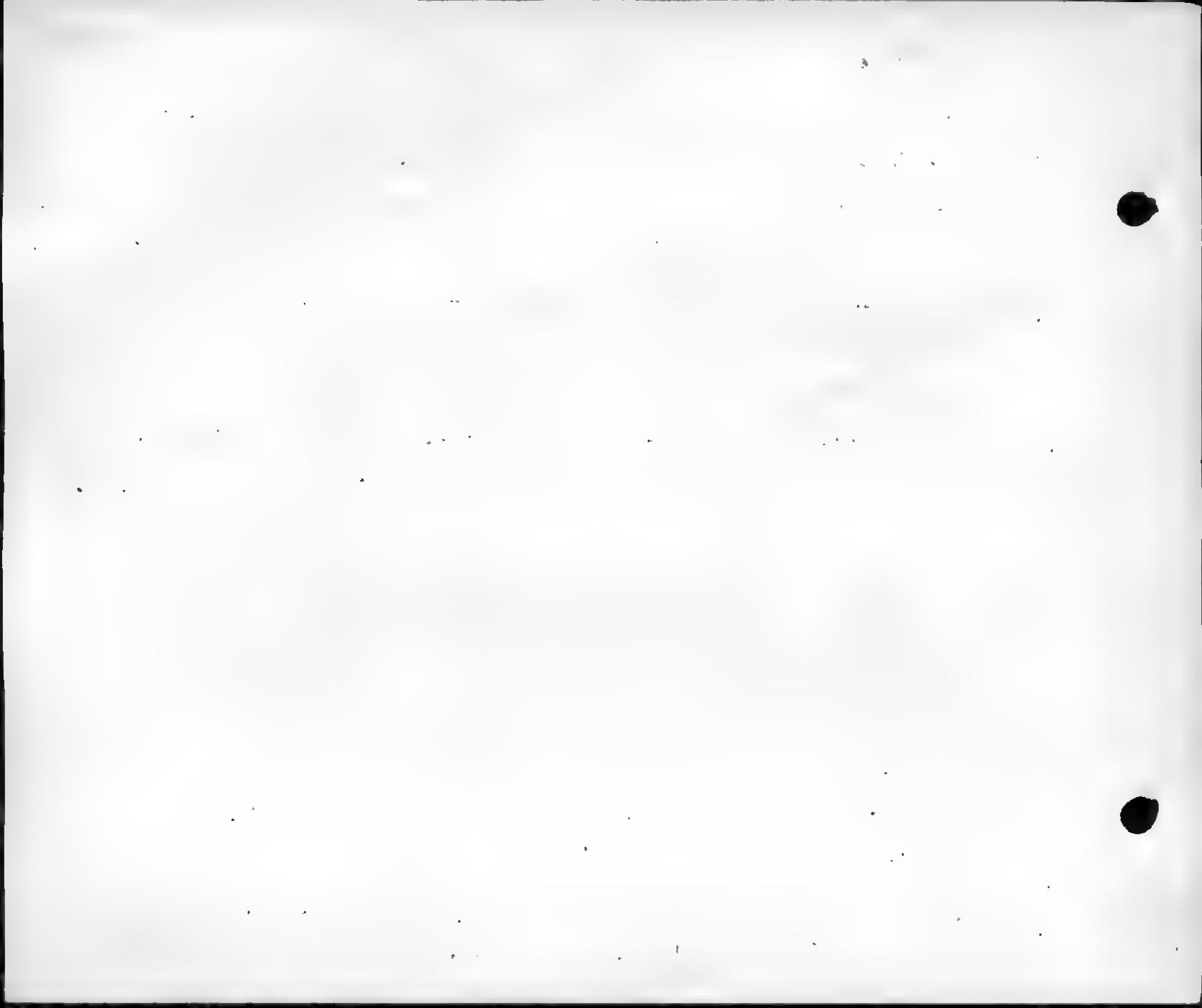
PHYSICIAN'S  
NAME (Type)

BERNARD A. FITZGERALD M.D. 817 UNIVERSITY BLVD E. 6-17-66

22a. BURIAL, CREMATION,  
REMOVAL (Specify)  
BURIAL 6/20/66 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or county) (State)  
ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D. BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  
JOS. GAWLER'S SONS, WASH., D.C. JUN 22 1966 Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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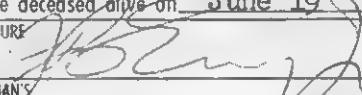
08576

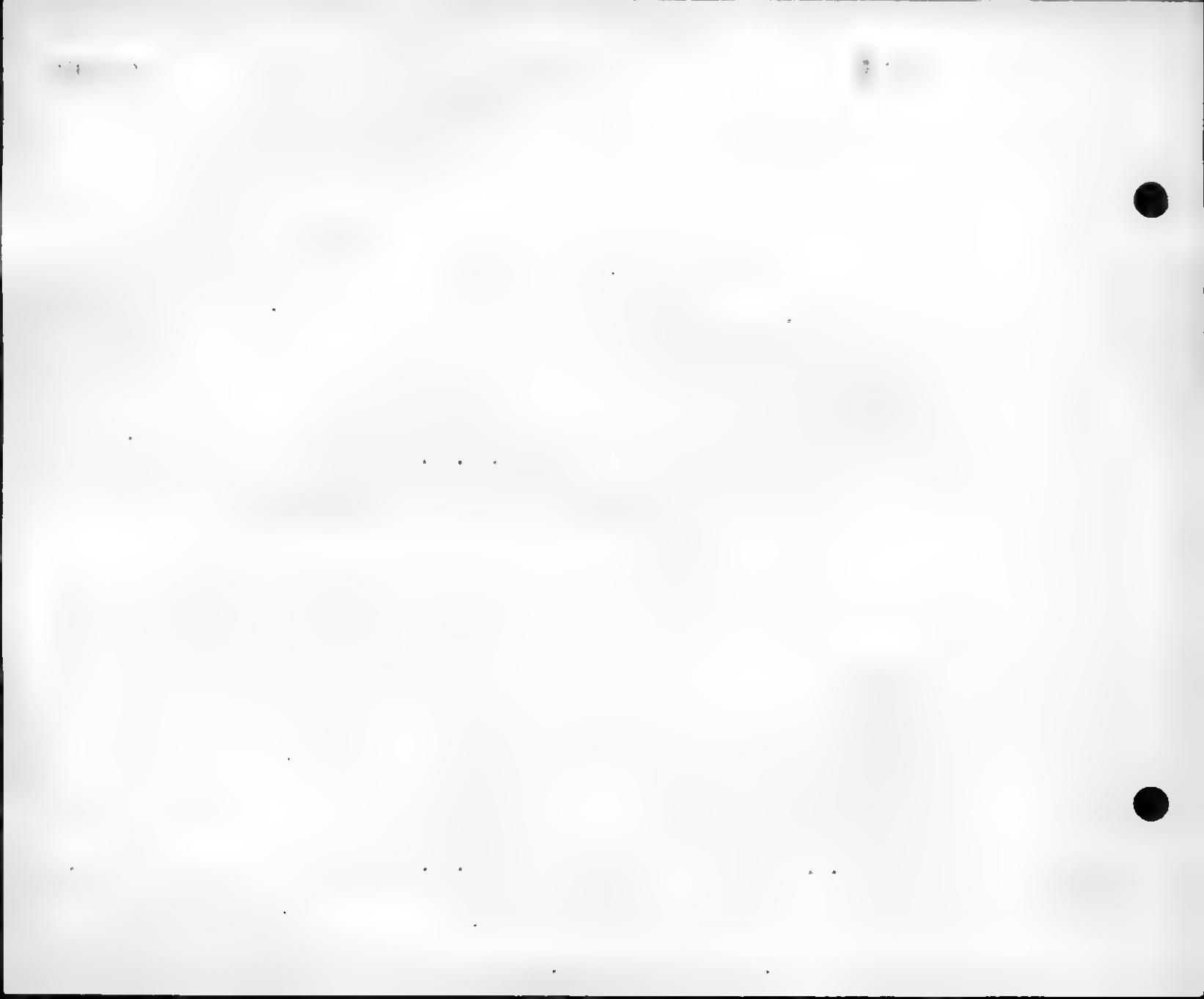
## CERTIFICATE OF DEATH

08566

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maine</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 16 <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eliot</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>24 Barney Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Ann F. CALLAHAN</b>		First	Middle	Lost	4. DATE OF DEATH <b>June 19 1966</b>	Month	Doy	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 3, 1891</b>	9. AGE (In years last birthday) <b>74</b> yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Dys	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Fletcher</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Bell</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Brookline</b> Address <b>Mass.</b> <b>Mrs. R. M. Mullins, 14 Fairbanks, Apt. 3/</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic and Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>-17-X</b>								
(b) <b> </b>								
DUE TO (c) <b> </b>								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 13</b> , 19 <b>66</b> , to <b>June 19</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 19</b> , 19 <b>66</b> , and that death occurred at <b>645AM</b> , from causes and on the date stated above.								
22a. SIGNATURE 		22b. DATE SIGNED <b>20 June 1966</b>						
22c. PHYSICIAN'S NAME (Type) <b>J.B. EMERY JR LT MC USN</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6-21-1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR <b>Pearsons Funeral Home</b>		ADDRESS <b>472 N. Washington, Falls Church, Va.</b>		25a. REC'D. BY REGISTRAR <b>JUN 22 1966</b>		25b. REGISTRAR'S SIGNATURE 		
VR A15 (4) 20 M 1/68								



IN M HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2 hour after death. Executed within 2 hours after death.

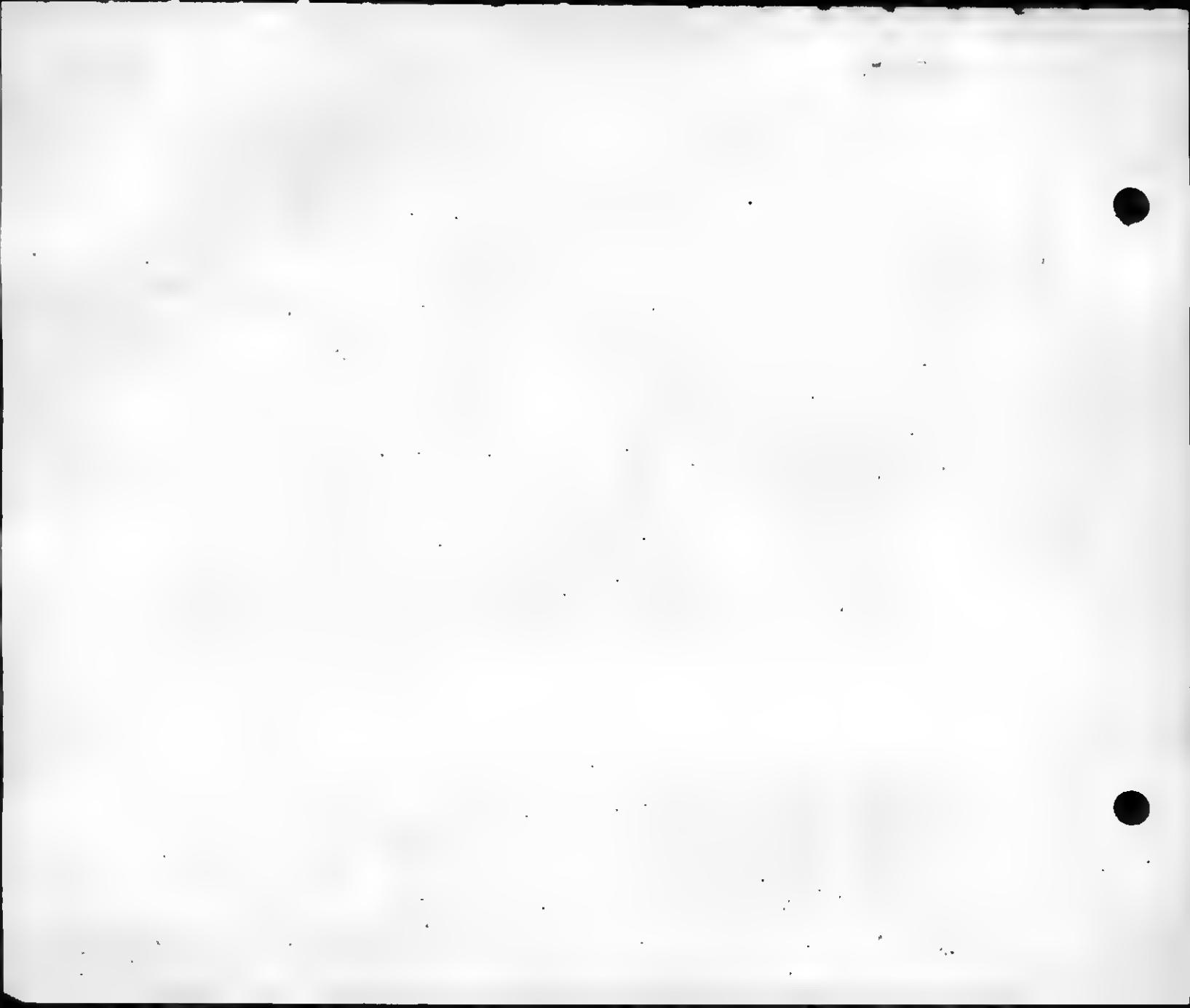
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08577

08567

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b>		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FAIRLAND NURSING HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver SPRING</b>	
3. NAME OF DECEASED (Type or print) <b>SARAH</b>		First - Last <b>CAPP</b>	4. DATE OF DEATH Month <b>JUNE</b> Day <b>2, 1966</b> Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>12-12-1881</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. 11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>	12. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. 13. CITIZEN OF WHAT COUNTRY? <b>Russia</b>
14. FATHER'S NAME <b>MEYER DARGSTEIN</b>		15. MOTHER'S MAIDEN NAME <b>ROSE DARGSTEIN</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>UNK.</b>	
18. INFORMANT PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coma</b>		19. INFORMANT Address <b>2445-Lyttonsville Rd. 511 SPG. MD</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>157X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7</b>	
(b) DUE TO Carcinomatosis		2 mo	
(c) DUE TO Carcinoma Pancreas		4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19, to <b>6-2, 1966</b> , that (I) (we) last saw the deceased alive on <b>5-31- 1966</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>6-2-66</b>	
22a. SIGNATURE <b>Samuel A. Hillman</b>		ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>6-2-66</b>
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL A. HILLMAN</b>		22d. ADDRESS <b>8829-FROEDER AVE. SSAGND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/5/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>MT. ZION Cem.</b>
24. FUNERAL DIRECTOR <b>Geelong Funeral Home</b>		ADDRESS <b>4217-9 2nd</b>	25a. REC'D BY REGISTRAR <b>JUN 6 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

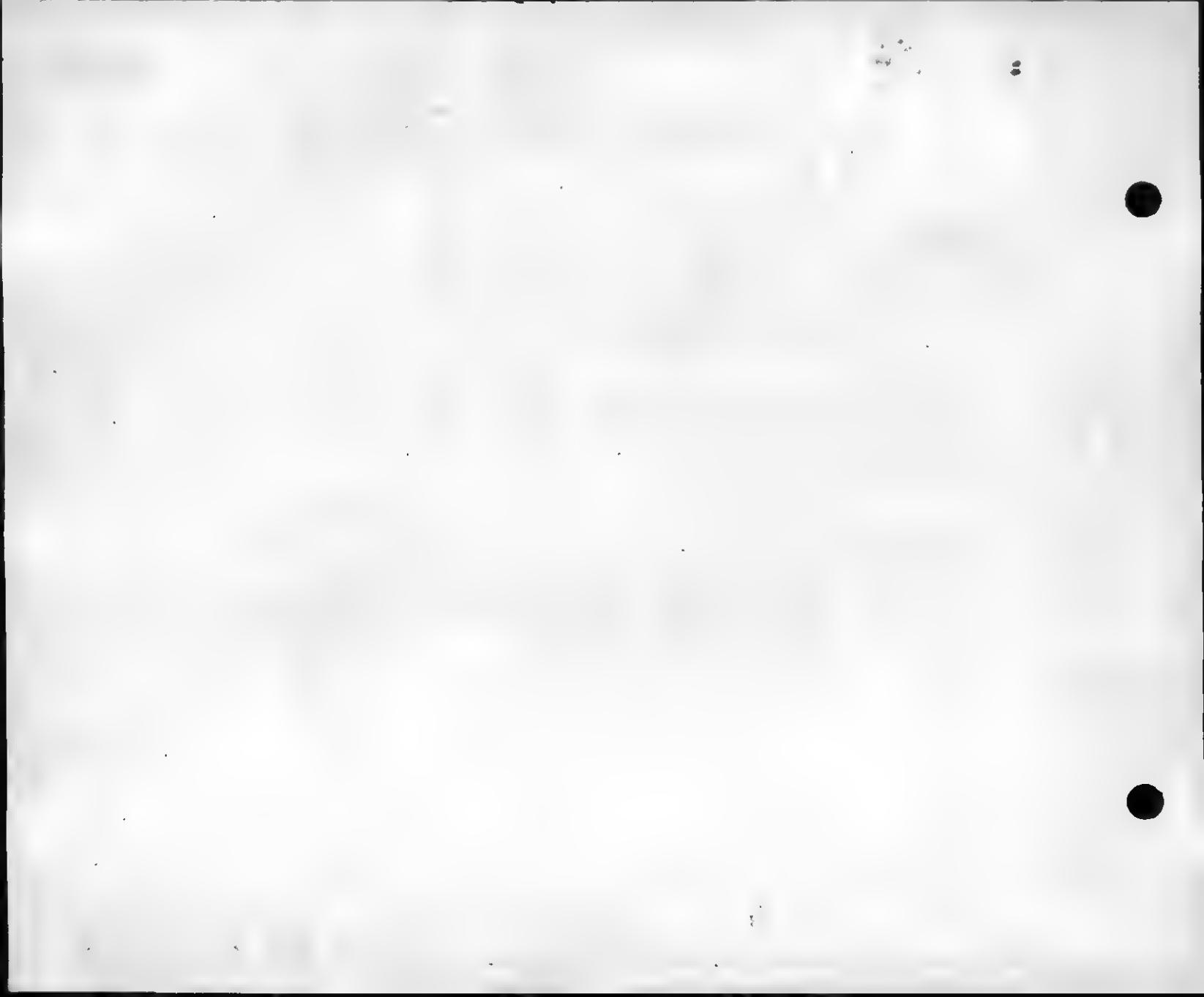
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

08568

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cathhaven Convalescent Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>5950-14th St. N.W.</i>		e. STREET ADDRESS								
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Leonard</i>	Last <i>Case</i>	4. DATE OF DEATH <i>June 20 1966</i>	Month <i>June</i>	Day <i>20</i>	Year <i>1966</i>	5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 5, 1878</i>	9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Paint</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George W. Case</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Robinson</i>		Address <i>Wash. 20011</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-03-4800</i>		17. INFORMANT <i>Eudyn Neppinger</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL Infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>						
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>30x</i>		DUE TO (b) <i>MULTIPLE CEREBRAL Thromboses</i>		DUE TO (c) <i>CEREBRAL ARTERIOSCLEROSIS</i>						3 weeks						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>—</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>		(State) <i>—</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>9 MARCH 1952</i> to <i>20 JUN 1966</i> , that (I) (we) last saw the deceased alive on <i>20 June 1966</i> , and that death occurred at <i>4:29 PM</i> , from the causes and on the date stated above.										22b. DATE SIGNED <i>20 June 1966</i>						
22a. SIGNATURE <i>Israel Kessler</i>		22b. ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <i>ISRAEL KESSLER, M.D.</i>		22d. ADDRESS <i>5801-16th St. N.W. Wash. D.C.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 23, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Burtonsville Union Cem.</i>		23d. LOCATION (City, town or county) <i>Burtonsville, Maryland</i>		(State)								
24. FUNERAL DIRECTOR <i>John P. Thompson</i>		ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>JUN 24 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>										
VR A15 (4) 15M 4-64																



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

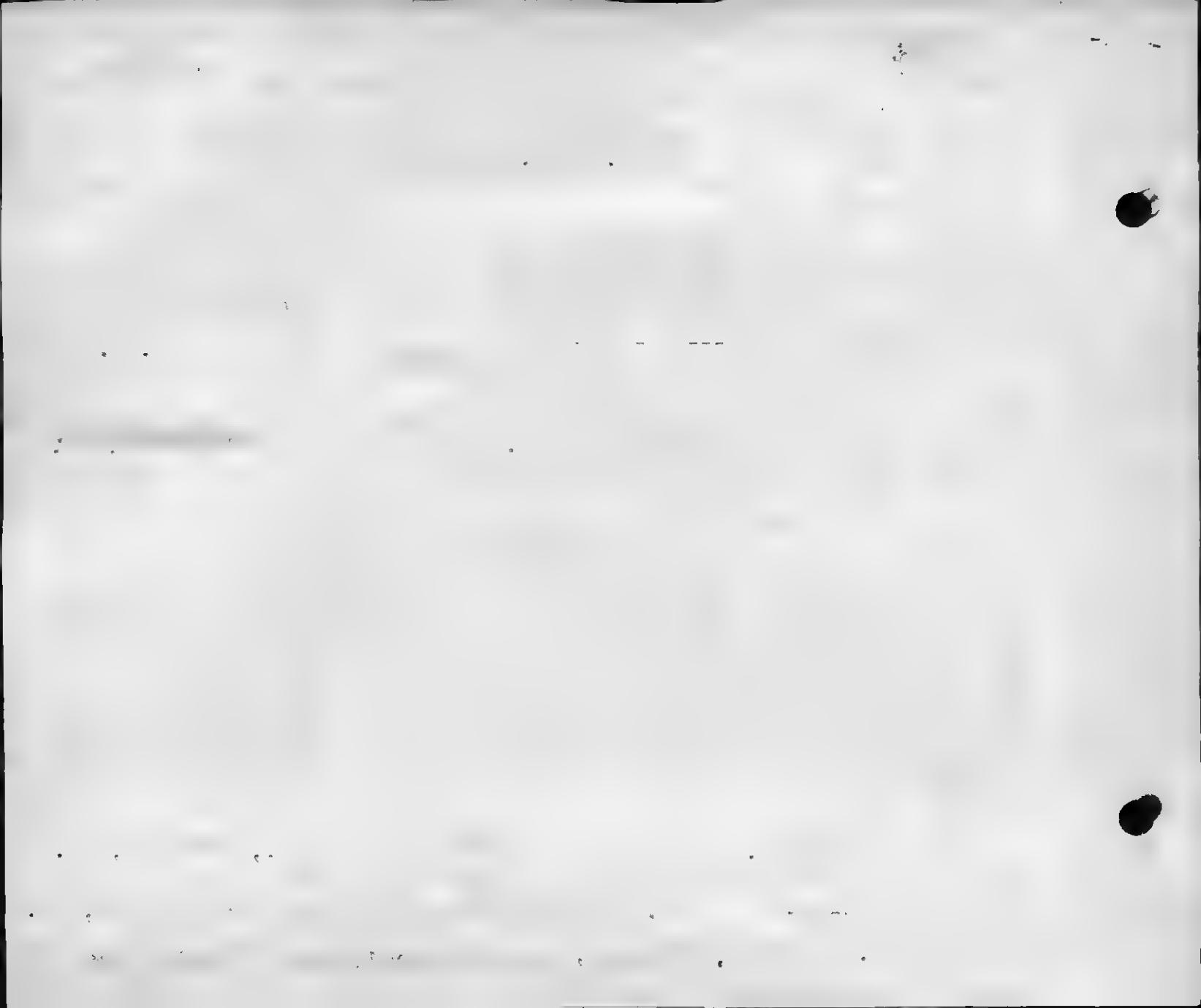
## CERTIFICATE OF DEATH

38575

08569

**TO HOSPITAL** \_\_\_\_\_ by be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 2 may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Wheaton</i>		b. COUNTY <i>Montgomery Co.</i>	
c. LENGTH OF STAY IN 1b <i>2 Mos. 17 Da.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Joseph's Hospital</i>		d. STREET ADDRESS <i>4624 38th Street, Bethesda</i>	
3. NAME OF DECEASED (Type or print) <i>L. C. Logan SHEPHERD</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 1, 1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Herbert Shepherd</i>		14. MOTHER'S MAIDEN NAME <i>Logan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Daughter</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Acc. due to</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Cerebral Atherosclerosis</i> (b) DUE TO (c) <i>ARTERIOSCLEROSIS.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>MARCH 9, 1954</i> to <i>JUNE 10, 1966</i> , that (I) (we) last saw the deceased alive on <i>JUNE 7, 1966</i> , and that death occurred at <i>7:15 P.M.</i> from the causes and on the date stated above.		22e. SIGNATURE <i>Robert G. Angle</i>	
22d. PHYSICIAN'S NAME (Type) <i>ROBERT G. ANGLE</i>		22e. ADDRESS <i>5009 Del Ray Ave., Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery	
23b. DATE THEREOF <i>6-13-66</i>		23d. LOCATION (City, town or county) <i>Prince George County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25e. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>JUN 15 1966</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08580

CERTIFICATE OF DEATH

08570

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
<p>a. COUNTY <u>Montgomery</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u></p> <p>c. LENGTH OF STAY IN 1b <u>14 years</u></p>		<p>a. STATE <u>MARYLAND</u></p> <p>b. COUNTY <u>Maryland</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u></p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Hospital</u></p>		<p>d. STREET ADDRESS <u>830 Union Blvd E.</u></p>	
<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>71 3 NAME OF DECEASED (Type or print) <u>Ada</u></p>		First	Middle
		Last	Coates
		4. DATE OF DEATH 6 19 1966	Month Day Year
<p>5. SEX <u>Female</u></p>		5. COLOR OR RACE <u>Caucasian</u>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
<p>7. MARRIED <input checked="" type="checkbox"/></p>		8. DATE OF BIRTH <u>Aug 5 - 1915</u>	9. AGE (in years lost birthday) <u>50 yrs</u>
<p>10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Calvert County, Md.</u>
<p>13. FATHER'S NAME <u>Daniel Wallace</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Ella Gross</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO <u>None</u></p>	
		<p>17. INFORMANT <u>Husband - Mr Edward C. Coates</u></p>	
		<p>Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p>		<p><u>Coronary (Myocardial Infarction)</u></p>	
<p>(b)</p>		<p><u>Arterosclerosis</u></p>	
<p>(c)</p>		<p><u>Diabetes Mellitus</u></p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. MEDICAL CERTIFICATION <u>High Blood Pressure</u></p>		<p>20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Secondary cerebral hemorrhage of the brain</u></p>	
<p>20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)</p>		<p>20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Failure</u></p>	
<p>20e. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u></p>		<p>20f. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)</p>	
		<p>(City or town) (County) (State)</p>	
<p>21. I certify that (1) this hospital attended the deceased from <u>6 - 5 - 1966</u>, to <u>6 - 19 - 1966</u>, that (1) we last saw the deceased alive on <u>6 - 19 - 1966</u>, and that death occurred at <u>2:23 PM</u>, from causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>Alan Robert Gair</u></p>		<p>22b. DATE SIGNED <u>6 - 19 - 66</u></p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>Alan Robert Gair MD</u></p>		<p>22d. ADDRESS <u>7777 Maple Ave, Takoma Park, Md.</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p>		<p>23b. DATE THEREOF <u>6-23-66</u></p>	
		<p>23c. NAME OF CEMETERY OR CREMATORIAL <u>Browns Ch. Cem</u></p>	
<p>24. FUNERAL DIRECTOR <u>James C. Seven Times, Frederick, Md.</u></p>		<p>25a. RICD BY REGISTRAR DATE <u>JUN 23 1966</u></p>	
		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

38582

## CERTIFICATE OF DEATH

118571

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tokoma Park</b>		b. COUNTY <b>Montgomery</b>	
c LENGTH OF STAY IN lb <b>32 hours</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tokoma Park</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		d STREET ADDRESS <b>821½ Flowers Ave.,</b>	
3. NAME OF DECEASED (Type or print) <b>Hattie E. (NANN)</b>		4. DATE OF DEATH <b>June 19 1966</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>Sept 17-1890</b>		9. AGE (In years lost birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. JSJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Mr. Pascale Brange</b>		14. MOTHER'S MAIDEN NAME <b>Mattie (Step-sister) Jane Wilkinson</b>	
15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>160-10-1234</b>	17. INFORMANT <b>Patient's chart</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic hypertensive cardiovascular disease</b> (b) <b>Diabetes mellitus.</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Montgomery</b> (County) <b>Maryland</b> (State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>June 17, 1966</b> , to <b>June 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>June 19, 1966</b> , and that death occurred at <b>375 University Blvd., Silver Spring, Md.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Raymond Bradshaw</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>6/19/66</b>
22c. PHYSICIAN'S NAME (Type) <b>RAYMOND BRADSHAW</b>		22d. ADDRESS <b>375 University Blvd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 22-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Glen Cemetery</b>
24. FUNERAL DIRECTOR <b>J. Charles Judge</b>		25a. ADDRESS <b>254 Carrollton N.W.</b>	25b. REC'D BY REGISTRAR <b>Charles Judge</b>
25c. DATE <b>JUN 21 1966</b>		25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may be sent, within 72 hours after death.



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

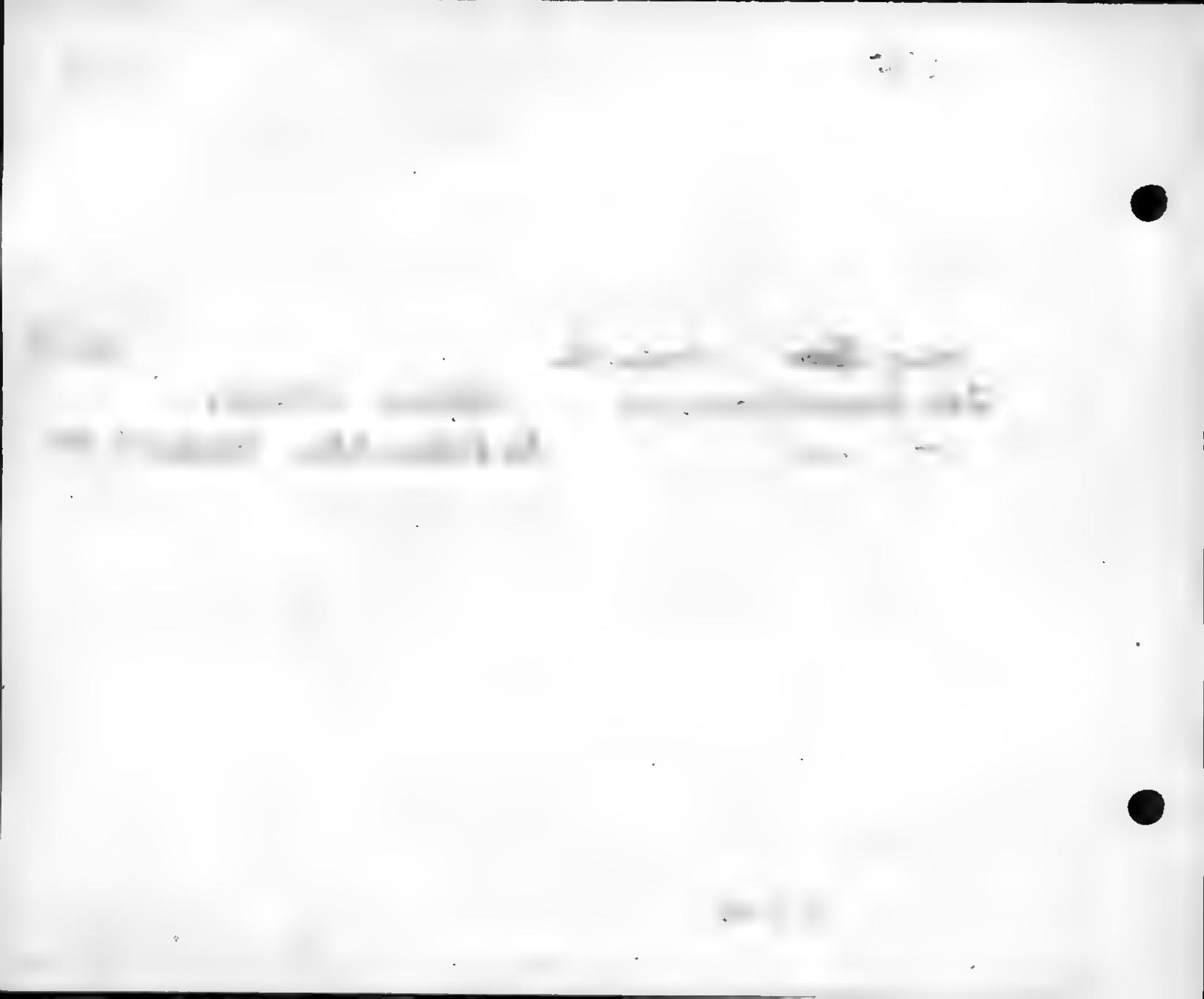
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08583

CERTIFICATE OF DEATH

118572

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING MD</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b <b>16</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING MD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSP.</b>		d. STREET ADDRESS <b>9713 WOODLAND DR SILVER SPRING MD</b>	
3. NAME OF DECEASED (Type or print) <b>PAULINE</b>		First <b>PAULINE</b>	Middle <b></b>
4. DATE OF DEATH Last <b>CONTOS</b>		Month <b>6</b>	Day Year <b>9 1966</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>6/21/00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME FRONT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>GREECE</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Triantafilopoulos</b>		14. MOTHER'S MAIDEN NAME <b>Chrysola Sitaras</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. Nicholas Fotos</b>		Address <b>ANNAPOLIS, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Coronary artery insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery thrombosis (c) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>		(County) (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 20</b> , 1956, to <b>June 9</b> , 1966, that (I) (we) last saw the deceased alive on <b>June 8</b> , 1966, and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Aaron H. Traum</b>		22b. DATE SIGNED <b>June 9 1966</b>	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-11-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ST. JAMES Cem.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR Sons Annapolis MD</b>		ADDRESS <b>—</b>	25a. REC'D BY REGISTRAR <b>JUN 13 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



FOR STATE  
HEALTH DEPT.

CE583

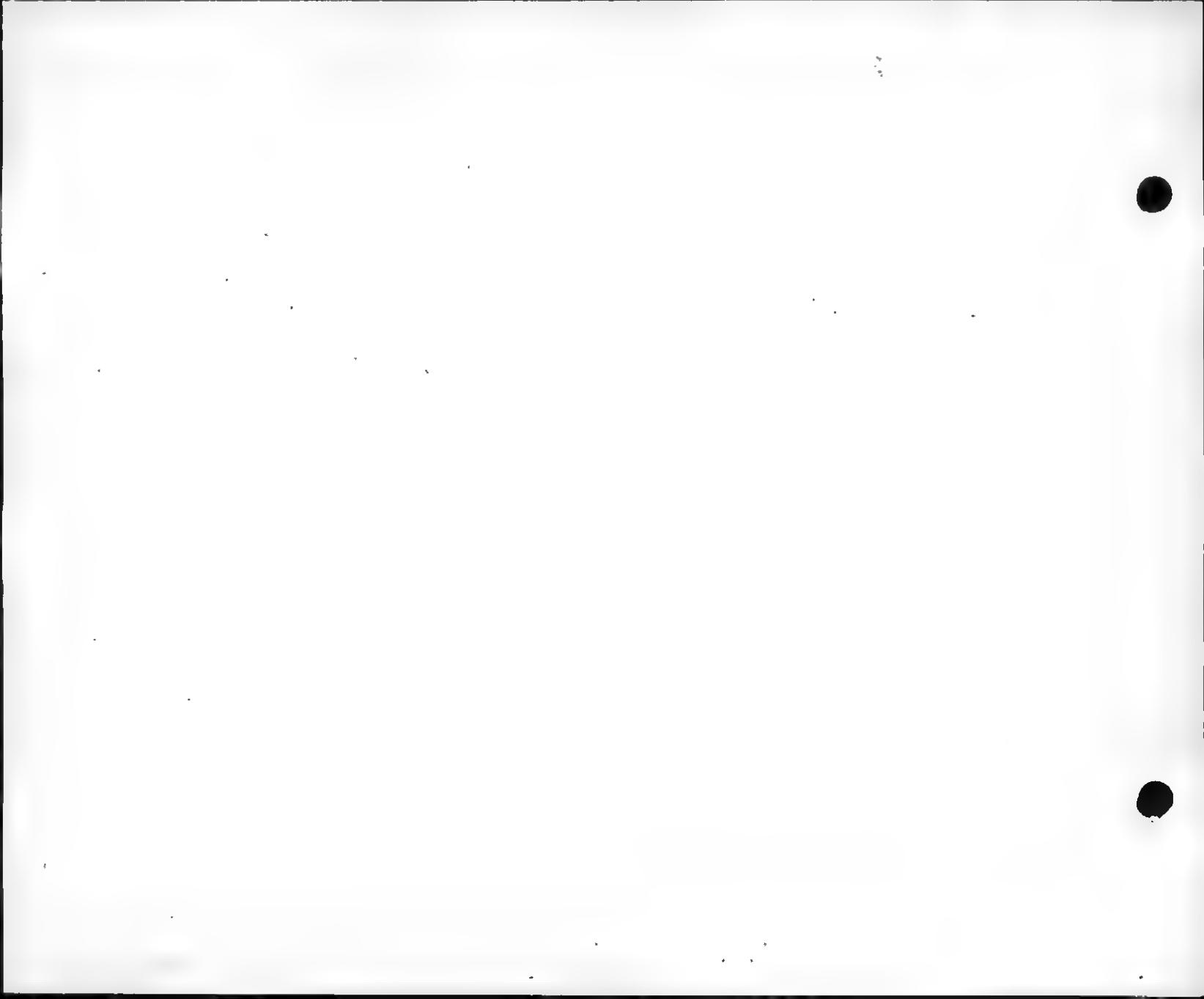
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18573

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>6011-84th Ave, Carrollton</b>	
3. NAME OF DECEASED (Type or print) <b>Ruth</b>		First <b>c.</b>	Mod e <b>Conway</b>
4. DATE OF DEATH <b>6 19 1966</b>	Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1-20-12</b>	9. AGE (In years last birthday) yrs <b>54</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. F. UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Boise, Idaho</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Frederick L. Cavis</b>		14. MOTHER'S MAIDEN NAME <b>Fern Reid</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO	17. INFORMANT <b>Sister Miss Mary Cavis</b>	Address <b>1245 Kurtz Rd. McLean, Va.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>8234</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Multiple, extreme trauma with hemi-decapitation due to auto accident.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18) <b>Decedent drove car which crossed median strip &amp; collided head-on with auto.</b>	
20c. TIME OF INJURY Month, Day, Year <b>11 09 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Street</b> (City or town) <b>Silver Spring</b> (County) <b>Maryland</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Belden, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>Ft. Myer, Va.</b>	
22. DATE SIGNED <b>June 19, 1966</b>			
23a. BURIAL, Cremation, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>6/22/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Ft. Myer, Va.</b>
24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b> 2901 14th St. N.W. Washington, D.C.	25a. ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>	25b. REC'D BY REGISTRAR <b>JUN 21 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

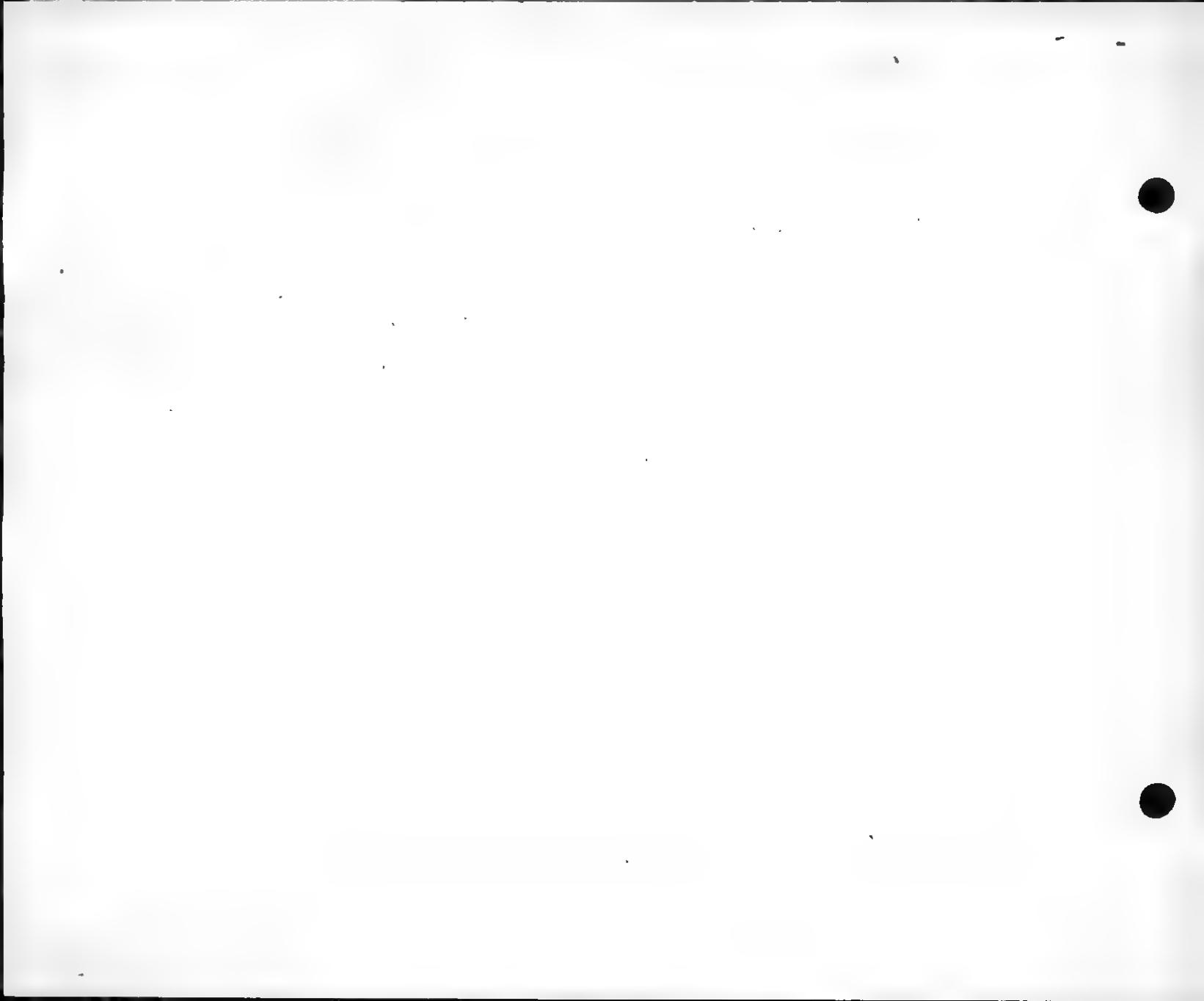


1 - M  
FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>							
c. LENGTH OF STAY IN 1b <i>3401 Univ. Blvd. West</i>				d. STREET ADDRESS <i>3401 Univ Blvd. W.</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3401 Univ. Blvd. West</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>Donald</i>	Middle <i>G.</i>	Lost <i>Cook</i>	4. DATE OF DEATH Month <i>6</i>	Month <i>26</i>	Day <i>1966</i>	Year			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>4-9--1922</i>	9. AGE (In years last birthday) <i>44</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. IF UNDER 24 HRS Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>truck driver</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>cleaning firm</i>			11. BIRTHPLACE (State or foreign country) <i>Suitland, md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>Walter J Cook</i>		14. MOTHER'S MATURE NAME <i>Zellie Mae Hubbard</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-18-8589</i>		17. INFORMANT <i>Mildred R. Cook - wife</i>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO Coronary artery heart disease (c)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) <i>Washington</i>		(County) <i>D.C.</i>		(State) <i>D.C.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Leap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.									
EXAMINER'S NAME (Type) <i>BELDEN R. LEAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <i>Washington</i>									
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/29/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City or Town) <i>Ft. Lincoln</i>		(County) <i>Prince George</i>		(State)	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Hom</i>		ADDRESS <i>1331 Rockville Pike Rockville</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 28 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15ME 66 6M 1/66											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate is executed within 24 hours after death.

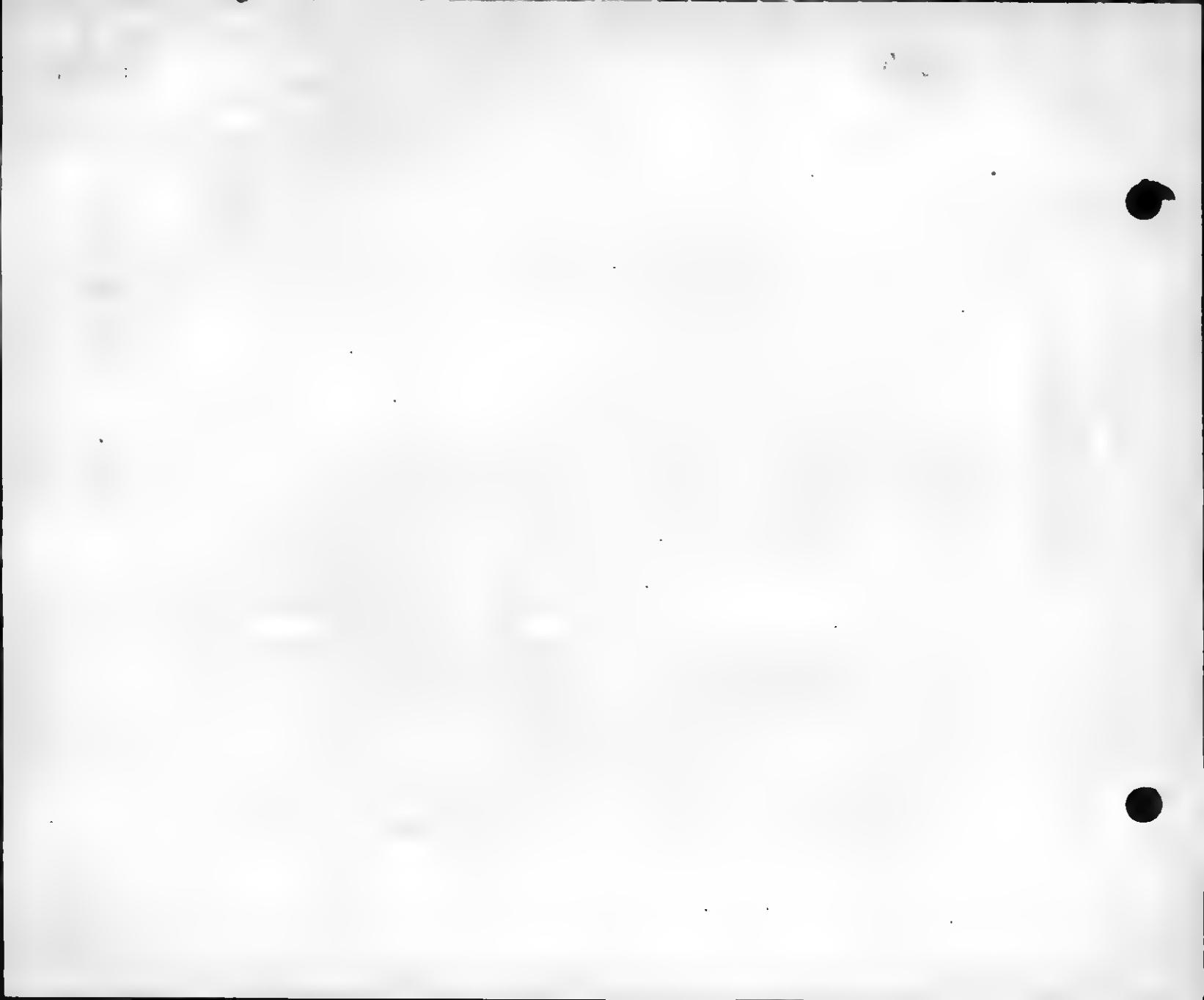
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08585 05575

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE VA. b. COUNTY <i>Chesterfield</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>15810 Bradford Rd.</i>	c. LENGTH OF STAY IN 1b <i>1 Day</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bradford Rest Home, Silver Spring</i>	d. STREET ADDRESS <i>Box 147A, Colonial Hgts.</i>			
3. NAME OF DECEASED (Type or print) <i>DAVID</i>	First <i>OSCAR</i> Middle <i>Copeland</i> Last	4. DATE OF DEATH <i>June 30</i> Month <i>1966</i> Day <i>Year</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-2-1897</i> 9. AGE (In years at birthday) <i>89</i> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardening</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co. Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Copeland</i>	14. MOTHER'S MARRIED NAME <i>Mary Darsay</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>214-18-805</i>	17. INFORMANT <i>Daughter &amp; Medical College Va.</i> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>				
DUE TO (b) <i>Coronary ARTERY Occlusion</i>				
DUE TO (c) <i>Generalized Arteriosclerosis</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus, Nephrosclerosis</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) <i>6-30</i> (County) <i>1966</i> (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-30</i> , 1966, to <i>6-30</i> , 1966, that (I) (we) last saw the deceased alive <i>6-22 2:00 p.m.</i> 19 <i>66</i> , and that death occurred at <i>3 AM</i> , from the causes and on the date stated above.			22b. DATE SIGNED <i>6-30-66</i>	
22a. SIGNATURE <i>Clive Jackson</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>202 Martin L. King, Jr. Blvd., Louisville, Ky.</i>		
22c. PHYSICIAN'S NAME (Type) <i>Clive Jackson</i>	23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7/3/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Jefferson Cemetery</i>	23d. LOCATION (City, town or county) <i>Louisville, Ky.</i> (State)
24. FUNERAL DIRECTOR <i>Robert L. Jackson, Louisville, Ky.</i>	ADDRESS <i>Robert L. Jackson, Louisville, Ky.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

108576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <i>Maryland</i> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> 30 days		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reno, Newburg, Maryland</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cherry Chase Nursing and Convalescent Center 2015 East-West Hwy</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <b>MR.</b> (Type or print) <i>James</i>		4. DATE OF DEATH <i>June 8 1966</i>	Month Day Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>May 28, 1879</i>
9. AGE (In years lost birthday) <i>87 yrs</i>	10. IF UNDER 1 YEAR Months <i>3046</i>	11. IF UNDER 24 HRS Days <i>31st. N. W. D. C.</i>	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurant Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Peter Cotsifas</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>577-03-7488</i>	
17. INFORMANT <i>Wilber E. Barclay</i>		Address <i>7046 31st. N. W. D. C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma larynx - generalized - exst</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>sit of origin unknown - probably</i> DUE TO (c) <i>renal</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 8, 1966</i> , to <i>June 8, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 7, 1966</i> , and that death occurred at <i>1:00 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>J. Meritis M.D.</i>		22b. DATE SIGNED <i>June 8-1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Fofo Meritis-M.D.</i>		22d. ADDRESS <i>1835 Eye St. New Wash DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL 6-11-66</i>		23b. DATE THEREOF <i>6-11-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>FORT LINCOLN</i>
23d. LOCATION (City or Town) <i>COPPER MANOR NJ.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Lee Funeral Home 300 4th St N.E.</i>		ADDRESS <i>Lee Funeral Home 300 4th St N.E.</i>	25a. REC'D BY REGISTRAR <i>JUN 13 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08587 08577

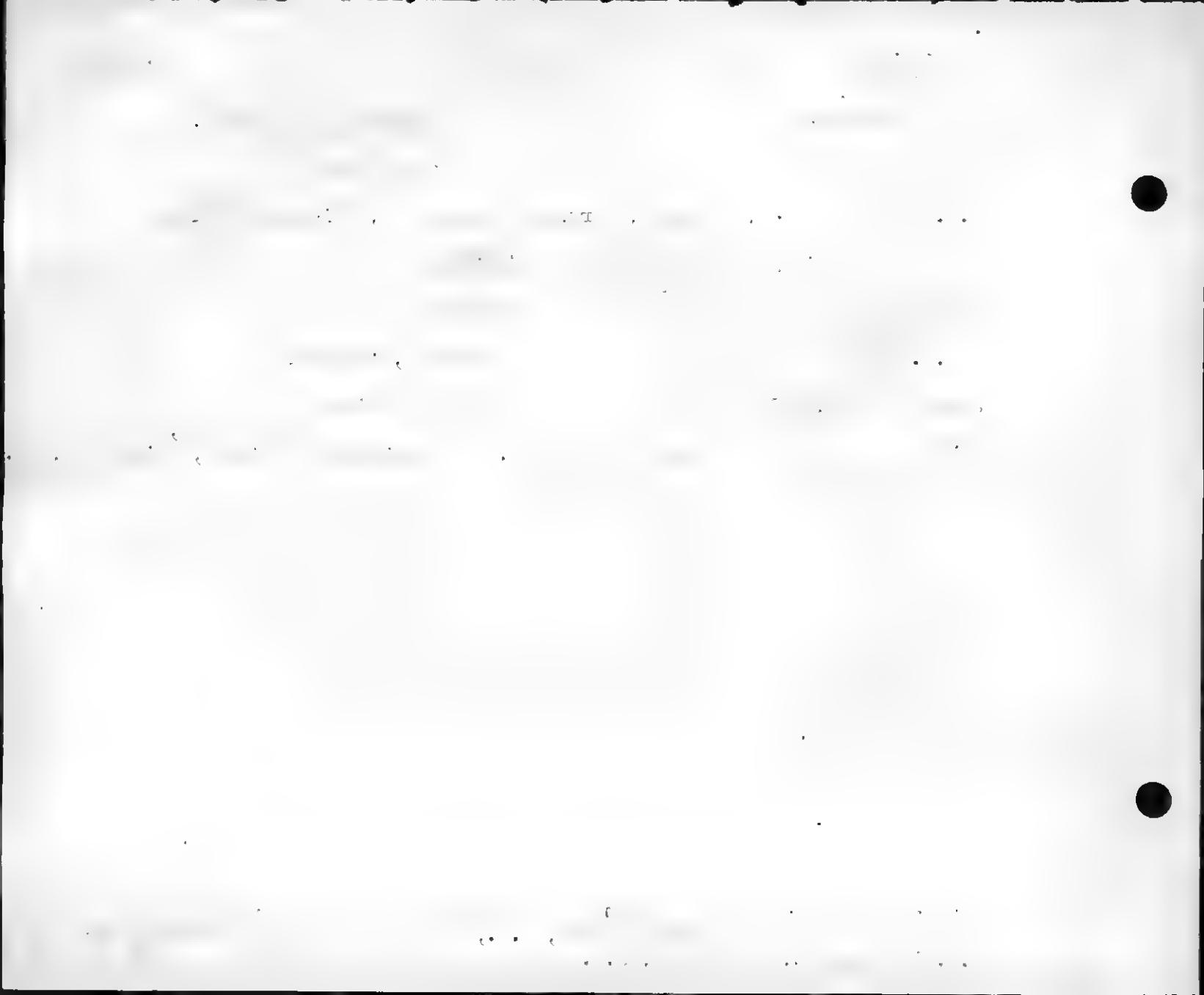
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		b. COUNTY <b>Harford</b>			
c. LENGTH OF STAY IN 1b <b>12 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Billy Wayne CRAWFORD</b>		4. DATE OF DEATH Month Day Year <b>June 6 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 August 1946</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Memphis, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James "J" Crawford</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Raines</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>415 21 2041</b>			
17. INFORMANT <b>Mrs. Carolyn Crawford Village, Bainbridge, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)  DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4:45 p.m. 5/20/66</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Tractor-Trailer-Truck turned over on top of Deceased car.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street.</b>		20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22. DATE SIGNED <b>6/7/66</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE THEREOF <b>JUNE 10, 1966</b>					
23c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Vernon Cemetery</b>					
23d. LOCATION (City, town or county) <b>Memphis, Tennessee</b>					
24. FUNERAL DIRECTOR ADDRESS <b>1400 Chapin Street, N.W., W.W. Chambers Co. Washington, D.C.</b>					
25a. REC'D BY REGISTRAR DATE <b>JUN 9 1966</b>					
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION

ACTUAL SIGNATURE *John G. Ball*

EXAMINER'S NAME (Type)

VR A1SME (5) 1/65



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08588

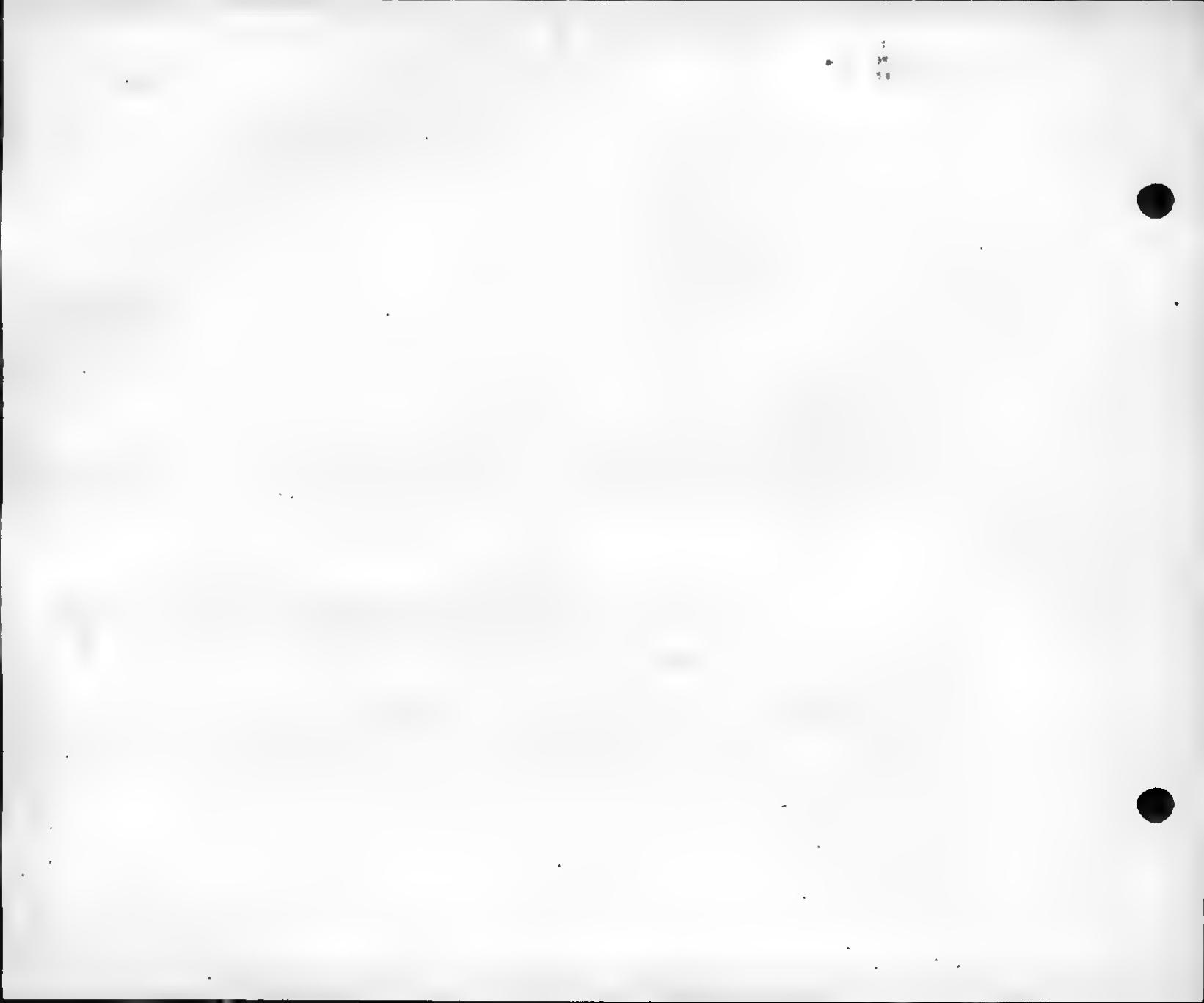
## CERTIFICATE OF DEATH

08578

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

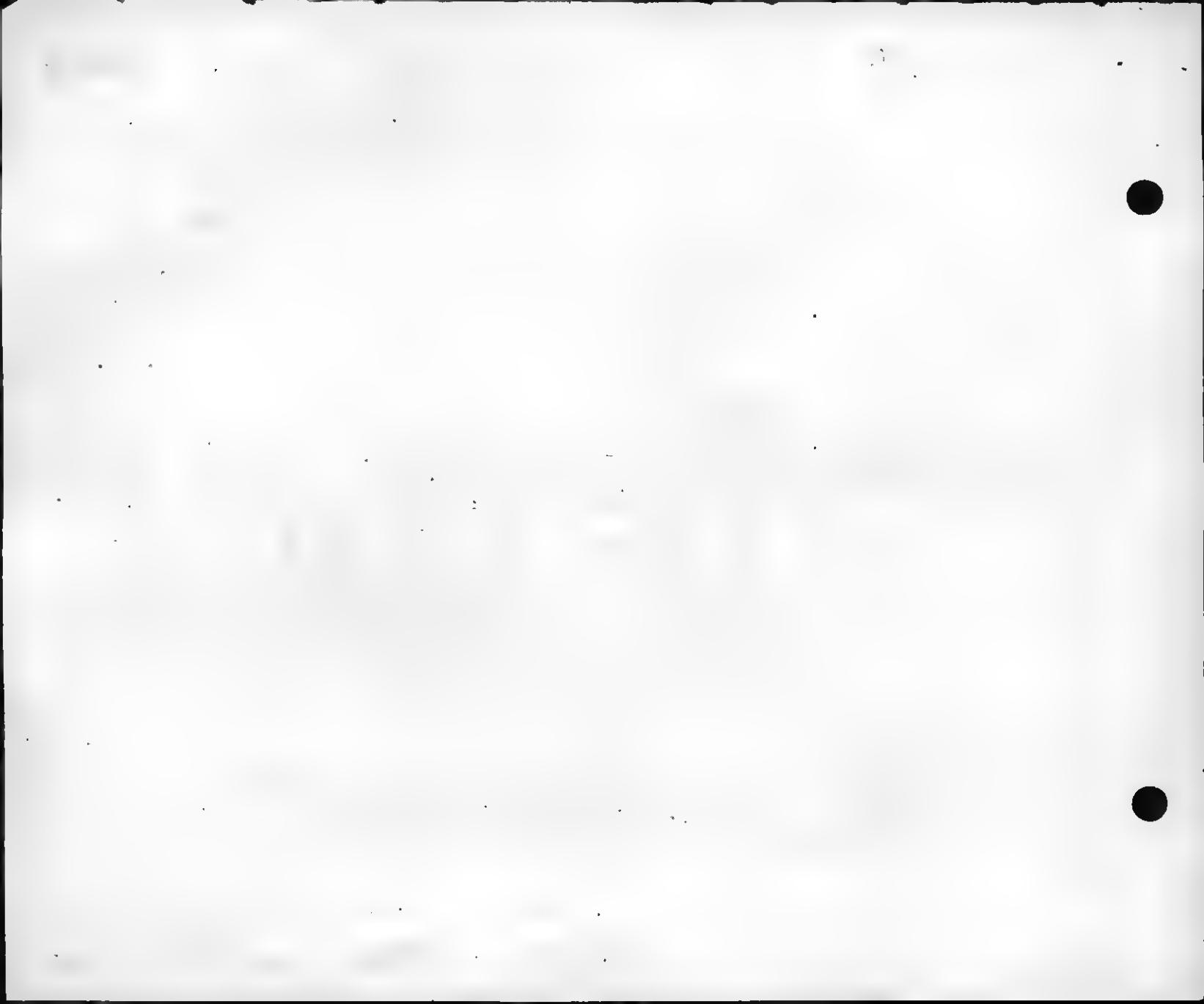
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 2 days						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium		d. STREET ADDRESS 6935 Laurel Ave						
3. NAME OF DECEASED (Type or print) Elizabeth Oakley Creech		First Last	Middle Month Year Date of Death June 29 1966					
4. SEX Female		5. COLOR OR RACE White	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-06	9. AGE (In years lost birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Casley		14. MOTHER'S MAIDEN NAME Marguerite Oakley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 577-20-0072		
17. INFORMANT Hospital Records - as above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		ACUTE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 78 hrs		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		19						
21. I certify that (I) (this hospital) attended the deceased from 6-27, 1966, to 6-29, 1966, that (I) (we) last saw the deceased alive on 6-28 1966, and that death occurred at 104 M, from causes and on the date stated above.							22b. DATE SIGNED 6-29-1966	
22c. SIGNATURE Eino Magi, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS 831 Univ. Blvd. E Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 2, 1966		23c. NAME OF CEMETERY OR CEMINATORY St. Lincoln		23d. LOCATION (City or Town) Baltimore County		
24. FUNERAL DIRECTOR Burke & Webb		ADDRESS 254 Carroll St. N.W. Washington, D.C. 20012		25a. REC'D BY REGISTRAR DATE JUL 5 1966		25b. REGISTRAR'S SIGNATURE Glenys Judge		



1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY		MARYLAND		a. STATE		b. COUNTY									
Montgomery				Maryland		Montgomery									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)							
Bethesda				15				14500 Avery Road 15-1							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)								d. STREET ADDRESS							
Suburban Hospital								Rockville, Maryland							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM?						
		Donald	Warren	Crown	June 12,			1966	YES	NO					
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	Months	Days	Hours				
Male		W.	WIDOWED	DIVORCED	11/26/07	58 yrs.					Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Painter								Maryland				U.S.A.			
13. FATHER'S NAME															
JAMES MARTIN				Crown				MARY BURRISS				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				INTERVAL BETWEEN ONSET AND DEATH			
Yes NAVY WW II				212-14-8464				James W Crown - Same as above				sev. weeks			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
5811				Hepatic failure								year			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b)				Cirrhosis of the liver				year			
				DUE TO (c)				Excessive alcohol intake				years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)				20f. (City or town) (County) (State)			
19															
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966, to June 12, 1966, that (I) (we) last saw the deceased alive on June 12, 1966, and that death occurred at M, from the causes and on the date stated above.															
22a. SIGNATURE George H. Mitchell															
22b. DATE SIGNED June 13 1966															
22c. PHYSICIAN'S NAME (Type) George H. Mitchell				22d. ADDRESS 4890 Battery Lane, Bethesda, Md.								20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/15/66				23c. NAME OF CEMETERY OR CREMATORIAL Laytonsville Meth. Ch.				23d. LOCATION (City, town or county) (State) Laytonsville, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rockville Pike Rockville, Maryland															
ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE JUN 15 1966 gCharles Judge							



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CC590

08580

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

a. COUNTY Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Kensington

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kensington Gardens

3. NAME OF DECEASED  
(Type or print)First  
CharlesMiddle  
C.Last  
Cunningham4. DATE  
OF  
DEATHMonth  
JuneDay  
27Year  
1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

Sept. 27, 1874

9. AGE (In years  
last birthday)

91

yrs.

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired-Janitor

10b. KIND OF BUSINESS OR INDUSTRY  
School Board11. BIRTHPLACE (County & State, or foreign country)  
Unknown12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S Maiden Name

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) 

16. SOCIAL SECURITY NO.

17. INFORMANT

217-32-2792

Kensington Gardens Rest Home, Kensington, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.   
} (b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

3 DAYS

UREMIA

CARDIAC &amp; RENAL ARTERIOSCLEROSIS 2 YEARS

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20c. TIME OF INJURY Month, Day, Year  
Hour e.m. 19  
p.m.20d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from MAY 1, 1966 to JUNE 27, 1966 that (I) (we) last  
saw the deceased alive on JUNE 25, 1966, and that death occurred at 10:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE

HORACE H. CUSTIS

22c. PHYSICIAN'S  
NAME (Type)

HORACE H. CUSTIS JR

1852 COLUMBIA RD NW

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22b. DATE  
SIGNED  
6/27/66

22d. ADDRESS

Gaithersburg, Md.

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF  
7/6/6623c. NAME OF CEMETERY OR CREMATORIAL  
Forest Oak

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Tyson Wheeler Funeral Home-1331 Rockville Pike  
Rockville, Md.

25a. REC'D BY REGISTRAR

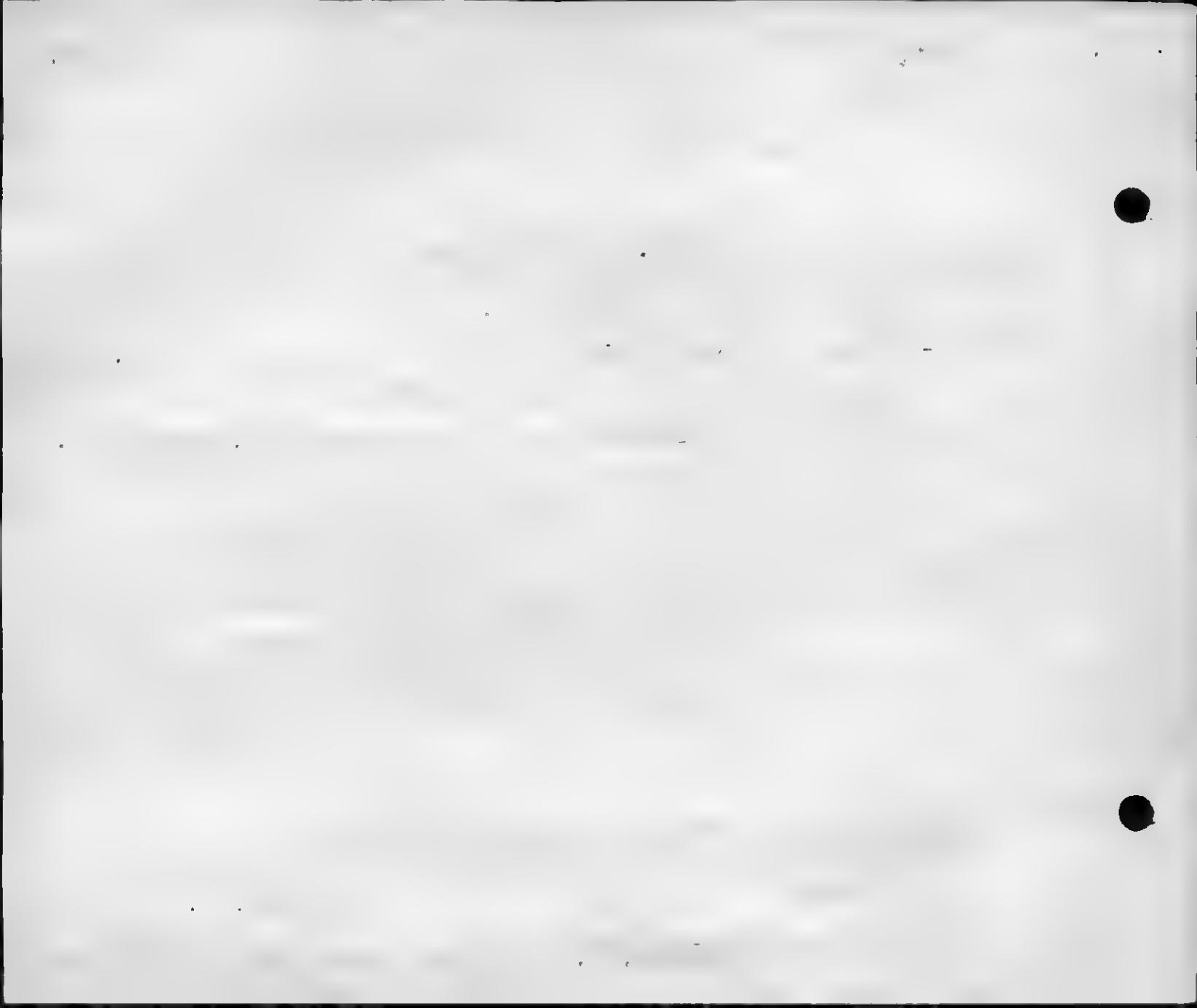
DATE JUL 8 1966

25b. REGISTRAR'S SIGNATURE

j Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15 9/60



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

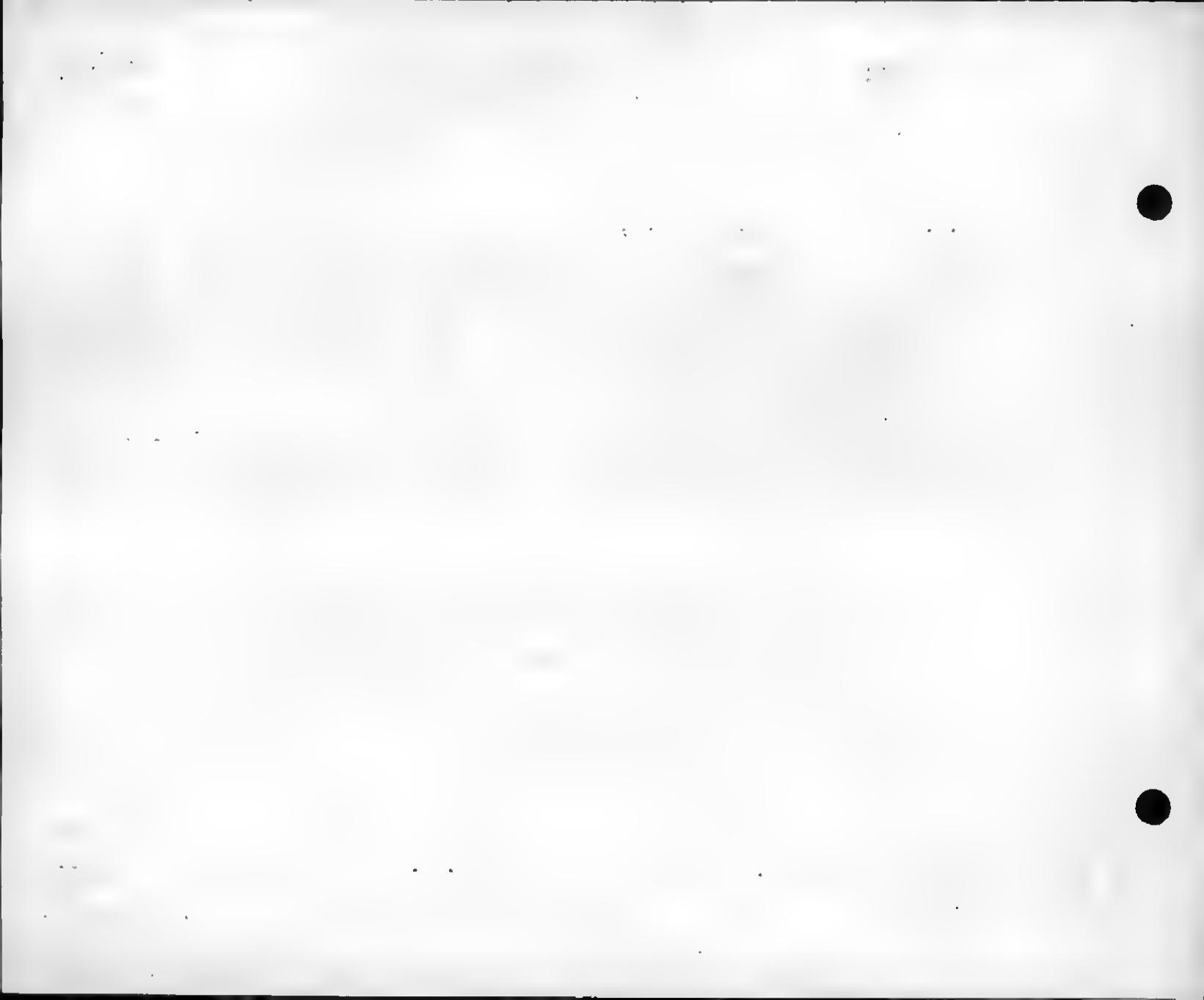
Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

08591 08581

1. PLACE OF DEATH a. COUNTY Montgomery			2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN MD 10 Hours		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midway Island		
3. NAME OF DECEASED (Type or print) First Ilvania (N)			4. DATE OF DEATH Month June Day 28 Year 1966		
5. SEX Female		6. COLOR OR RACE Negroid	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 13 April 1966
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		9. AGE (In years last birthday) yrs 2 12	
13. FATHER'S NAME Leon "D" Davis			11. BIRTHPLACE (County & State, or foreign country) Quantico, Virginia		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			14. MOTHER'S MAIDEN NAME Freddie Mae Hills		
16. SOCIAL SECURITY NO NA			17. INFORMANT 175 Telegraph Road, Leon "D" DAVIS Midway Island, Virginia		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 175 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (X) this hospital attended the deceased from 27 June, 1966 to 28 June, 1966 that (X) we last saw the deceased alive on 28 June 1966, and that death occurred at 8:05 A.M. from causes and on the date stated above.					
22a. SIGNATURE James A. Murray			22b. DATE SIGNED 29 June 1966		
22c. PHYSICIAN'S NAME (Type) James A. Murray LT MC USA			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-30-66		23c. NAME OF CEMETERY OR CREMATORIAL Star Bethlehem Church Cemetery	
24. FUNERAL DIRECTOR Bailey Funeral Home		ADDRESS 1311 Charles Street Fredericksburg, Virginia		25a. REC'D BY REGISTRAR DATE JUN 30 1966	
VR A15 (4) 20 M 1/66				25b. REGISTRAR'S SIGNATURE Charles Judge	

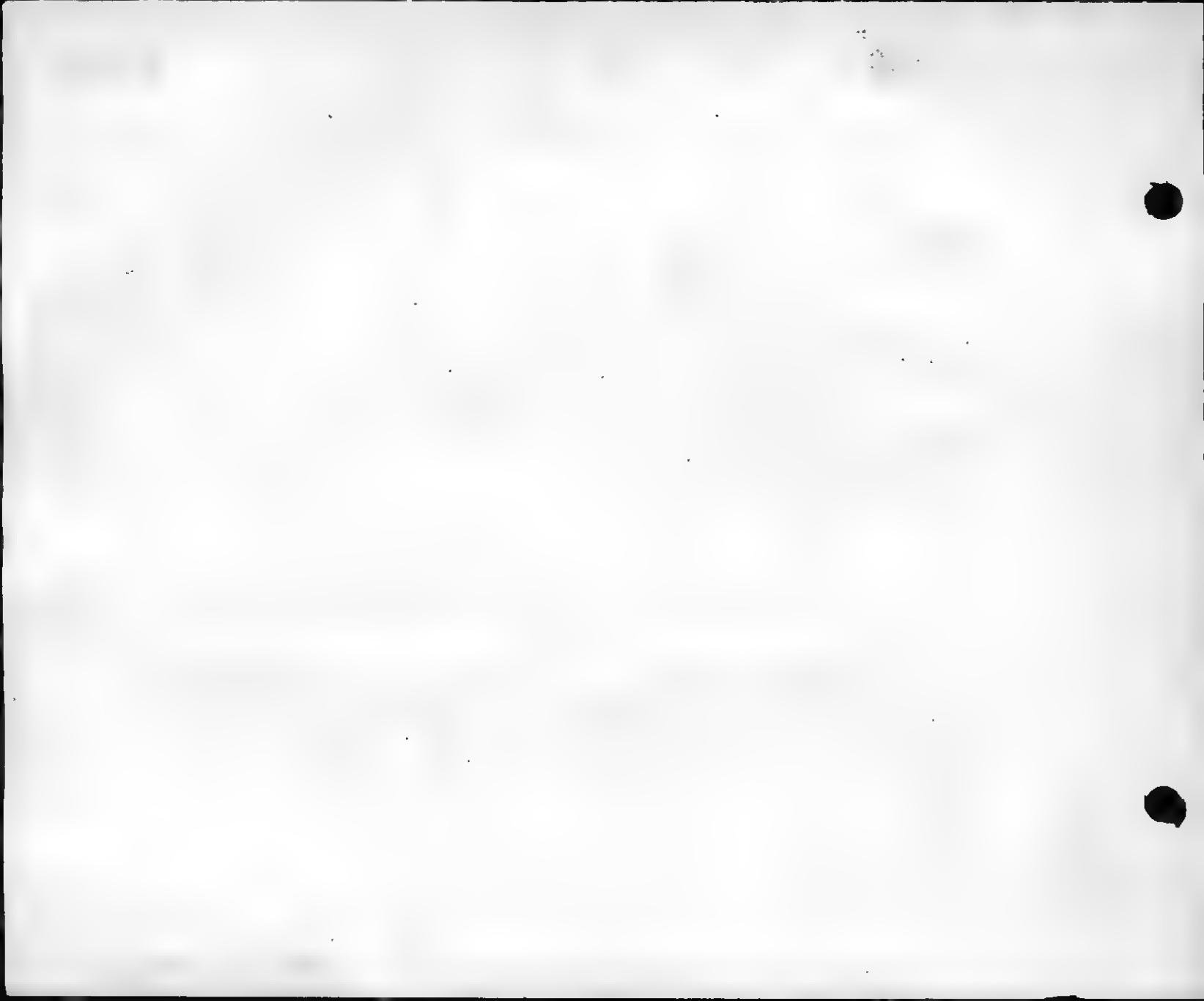


1  
FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give copies to Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE											
08592 Montgomery				MARYLAND b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1hr 33 min.											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg											
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
William						DAVIS	JUNE	6	19	66					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.					
M		C		NEVER MARRIED		5-30-1900		66		yrs.					
WIDOWED		Sep		DIVORCED											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Davis Sr.				14. MOTHER'S MAIDEN NAME Ada Cartwright				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
												17. INFORMANT Uncle - Henson Davis - Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleuritis, acute, with pleural effusion, confluous DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												Address INTERVAL BETWEEN ONSET AND DEATH weeks?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22. DATE SIGNED 6/7/66			
ACTUAL SIGNATURE John S. Bell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type)				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/14/66				23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park								23d. LOCATION (City, town or county) Rockville, Md. (State)			
24. FUNERAL DIRECTOR Robert H. Snowden Rockville, Md.				ADDRESS								25a. REC'D BY REGISTRAR JUN 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



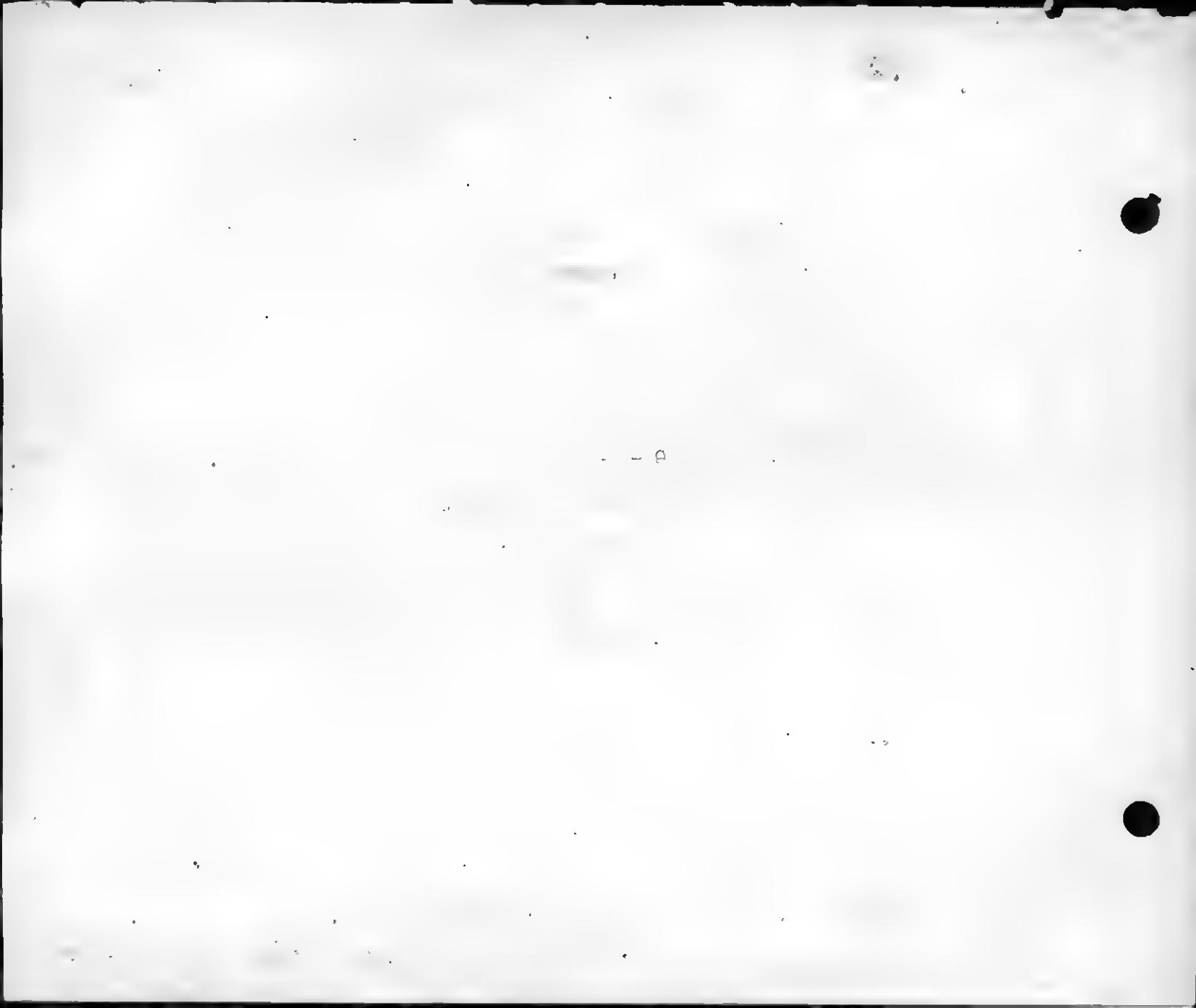
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1 M 08593		Items 230, 23d Film 0371 617/66 mb		118583	
		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		2. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
1. PLACE OF DEATH 6. COUNTY		c. LENGTH OF STAY IN 1b MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>SILVER SPRING</u> 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>676 West Fayette St.</u>	
e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <u>Isom</u>	Middle <u>Joseph</u>	4. DATE OF DEATH <u>Dean</u>	Month <u>6</u> Day <u>1</u> Year <u>1966</u>
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/28/04</u>	9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE AGENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Xy</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Dean</u>		14. MOTHER'S MAIDEN NAME <u>Lenis</u>		Address <u>Miss Aidebella Dean 500 W. University Pkwy.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>World War II 405-24-2309</u>		17. INFORMANT INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177x</u>		Carcinoma of prostate		Known since <u>July 23, 1966</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <u>Metastatic carcinoma to bones and liver</u>	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Acute pancreatitis			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Baltimore</u>	(County) (State) <u>Baltimore, Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>May 22, 1966</u> to <u>June 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 1, 1966</u> , and that death occurred at <u>1A</u> M, from the causes and on the date stated above.		22b. DATE SIGNED <u>June 1, 1966</u>			
22a. SIGNATURE <u>Dean H. Traum</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>June 1, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Georgia Ave - Silver Spring Rd</u>		22d. ADDRESS <u>8237 Georgia Ave - Silver Spring Rd</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> 6/8/1966		23c. NAME OF CEMETERY OR CREMATORIUM <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Ticknor &amp; Sons</u>		ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE JUN 3 1966	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



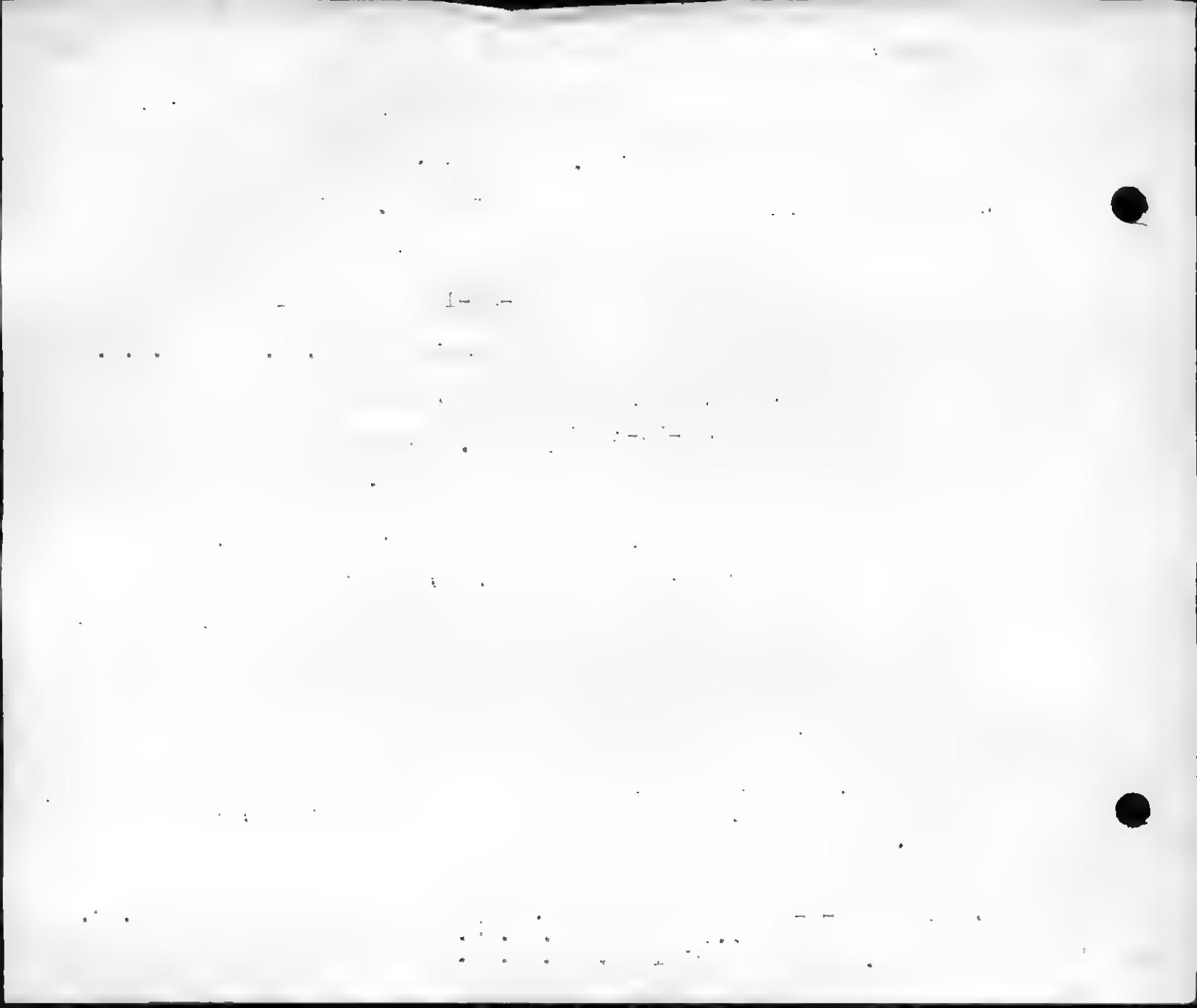
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 018584

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

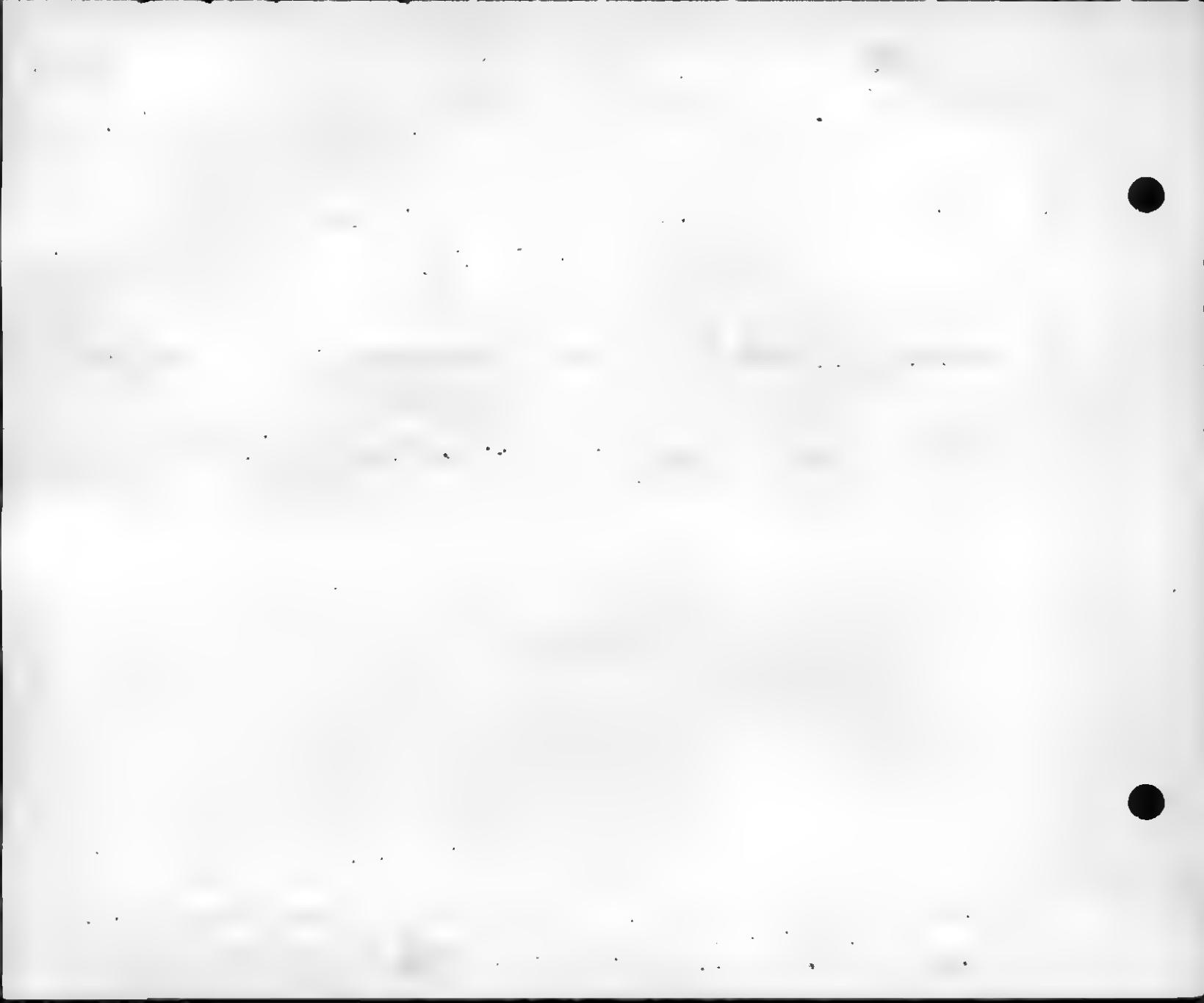
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institut. or Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN lb <b>20 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOLY CROSS HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>	
3. NAME OF DECEASED (Type or print) <b>ELEANOR</b>		d. STREET ADDRESS <b>10607 ST. PAUL STREET</b>	
4. DATE OF DEATH <b>C DeBettencourt</b>		Month <b>6</b>	Day <b>2</b>
5. SEX <b>F</b>		Year <b>1966</b>	
6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-14</b>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>51</b>	10. IF UNDER 1 YEAR Months <b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>
13. FATHER'S NAME <b>WILLIAM SIDNEY CARROLL</b>		14. MOTHER'S MAIDEN NAME <b>MINA ESPEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>578-12-1046</b>	INFORMANT <b>JOHN M. deBETTENCOURT</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <b>SAME AS # 2</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Myocardial Infarction, massive post. LV.</b>			
DUE TO <b>After atherosclerotic occlusion, L. Circumflex Artery</b>			
(b) DUE TO <b>C. A.</b>			
(c) DUE TO <b>Arteriosclerosis/C. A./Generalized</b>		Years <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (a) <b>DIABETES MELLITUS, myocardial scarring</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL</b> , 1966, to <b>MAY 15</b> , 1966, that I last saw the deceased alive on <b>5/15</b> , 1966, and that death occurred at <b>M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>915 19th St. NW, WASHDC 6/2/66</b>	
ACTUAL SIGNATURE <i>William Kurstin</i>		DATE SIGNED <b>6/2/66</b>	
PHYSICIAN'S NAME (Type) <b>William Kurstin MD</b>			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-6-66</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>MT OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) <b>WASHINGTON, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>		ADDRESS <b>WASH. D. C.</b>	
FRANCIS J. COLLINS 3821 14TH. ST. N. W.		23. DATE BY REGISTRAR <b>JUN 5 1966</b>	
		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY <i>Montgomery</i>				a. STATE <i>Maryland</i>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				b. COUNTY <i>Montgomery</i>											
c. LENGTH OF STAY IN 1b <i>13 hrs. - 10 mins.</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>				d. STREET ADDRESS <i>10225 Kensington, Pkwy Apt. 615</i>											
3. NAME OF DECEASED (Type or print) <i>Alice</i>				First <i>Alice</i>	Middle <i>NIN</i>	Last <i>DeL'ecchio</i>	4. DATE OF DEATH <i>June 2, 1966</i>	Month <i>June</i>	Day <i>2</i>	Year <i>1966</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <i>Female</i>				6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-17-99</i>	9. AGE (in years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. HOURS Hours <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Montgomery Ret. Teacher</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Put. College</i>				11. BIRTHPLACE (County & State, or foreign country) <i>England Scotland</i>				12. CITIZEN OF WHAT GREAT COUNTRY <i>England Britain</i>			
13. FATHER'S NAME <i>Quinn</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>								Address <i>Hospital Records 7600 Carroll Avenue</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>				16. SOCIAL SECURITY NO. <i>None YES</i>				17. INFORMANT <i>Hospital Records</i>				INTERVAL BETWEEN ONSET AND DEATH <i>None</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure, anasarca fib</i>															
42-1 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Early arteriosclerosis, &amp; fibrosis</i>															
(c) <i>Arteriosclerosis. Cause unknown</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>7/10/1960</i> to <i>6/11/1966</i> , that (I) (we) last saw the deceased alive on <i>6/11/1966</i> , and that death occurred at <i>12:00 A.M.</i> from the causes and on the date stated above.															
22a. SIGNATURE <i>Chas H. Wolohon M.D.</i>				22b. DATE SIGNED <i>6-2-66</i>											
22c. PHYSICIAN'S NAME (Type) <i>Chas H. Wolohon</i>				22d. ADDRESS <i>831 University Grade St. Mt. Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>June 4, 1966</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Mansoleum</i>				23d. LOCATION (City, town or county) (State) <i>Prince Georges Co. Md.</i>			
24. FUNERAL DIRECTOR <i>J. B. Shookas 8434 Georgia Avenue</i>				ADDRESS <i>Warren E. Pumphrey, Inc. Silver Spring, Md.</i>								25a. REC'D BY REGISTRAR <i>JUN 6 1966</i>			
												25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

20596

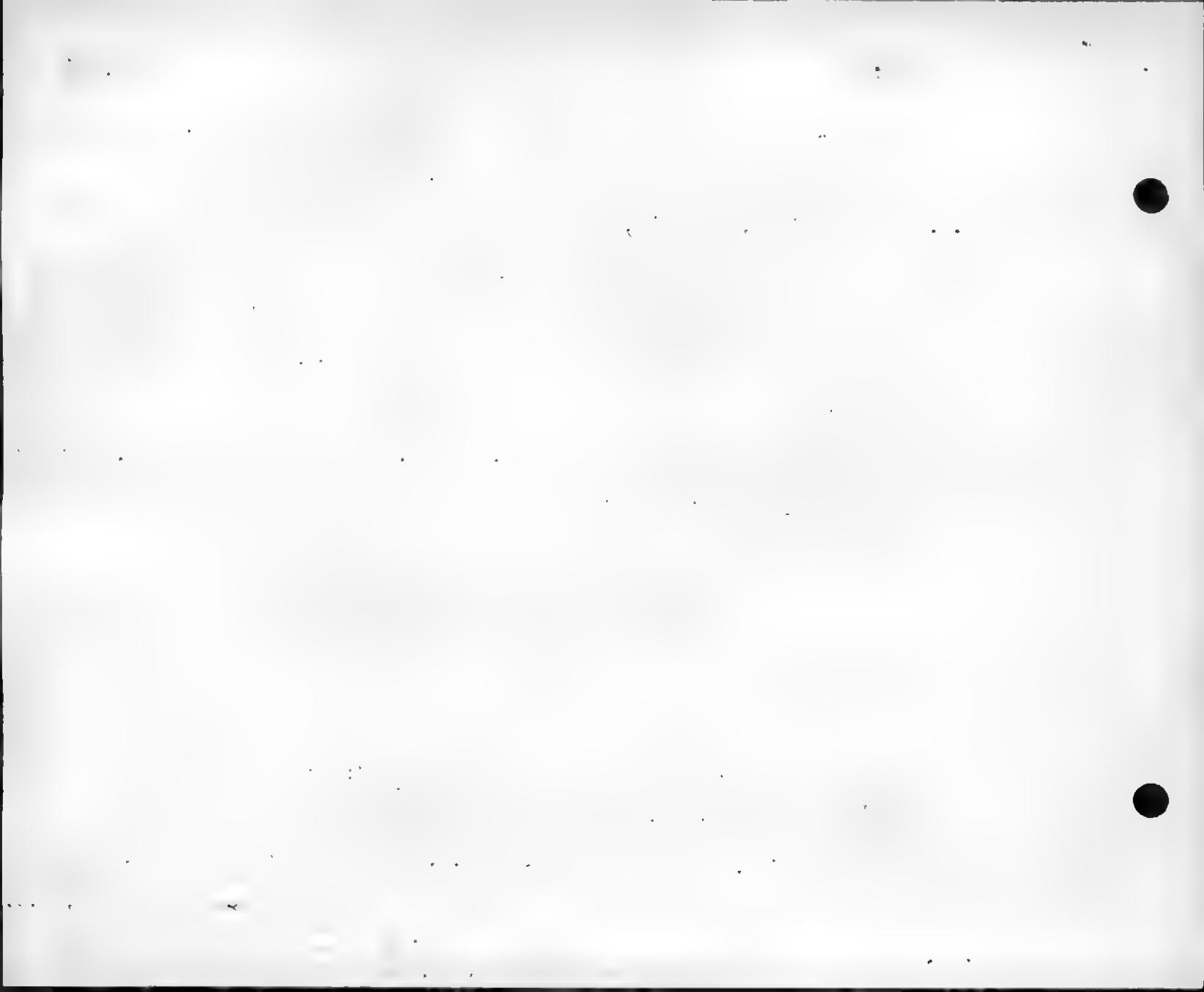
## CERTIFICATE OF DEATH

18586

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>17 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. NAVAL HOSPITAL, BETHESDA, MARYLAND</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
3. NAME OF DECEASED (Type or print) <b>Ruth Brown</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <b>X</b>	8. NEVER MARRIED DIVORCED <b>X</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9. DATE OF BIRTH <b>11 JUNE 1892</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		9. AGE (In years lost birthday) <b>73 yrs</b>	
13. FATHER'S NAME <b>"W" "B" Brown</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pinestone, Minnesota</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Mr. Paul R. Donaldson</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Myocardial Infarction</b>		19. INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5219 Palco Place, College Park, Maryland</b>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>21 May</b> , 1966, to <b>6 June</b> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 June</b> , 1966, and that death occurred at <b>7:10 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Raymond B. Johnson</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Raymond B. Johnson</b>		22b. DATE SIGNED <b>7 June 1966</b>	
22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>		23d. LOCATION (City or Town) <b>of Medicine, Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7 June 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>George Washington School</b>		23d. LOCATION (City or Town) <b>(County) (State)</b>	
24. FUNERAL DIRECTOR <b>R. A. Pumphrey Funeral Home, 7557 Bethesda, Md.</b>		25a. ADDRESS <b>Wisconsin Ave.</b>	
		25b. DATE <b>JUN 8 1966</b>	
		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08597

## CERTIFICATE OF DEATH

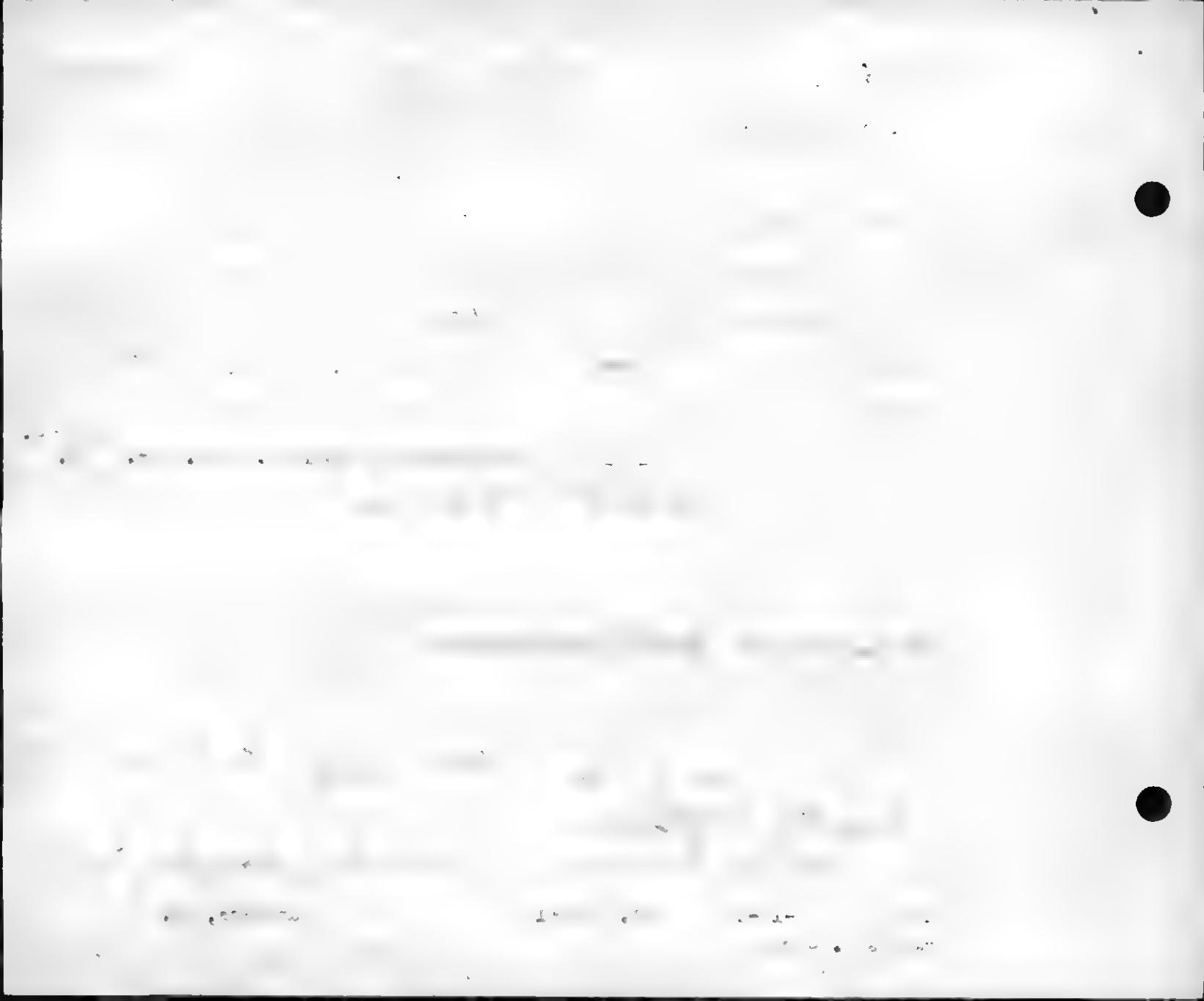
08587

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of remains in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		e. STREET ADDRESS 615 Mississippi Avenue	
3. NAME OF DECEASED (Type or print) Cordelia Hobbs		4. DATE OF DEATH June 8 1966	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED	8. DATE OF BIRTH 17/20/1884
9. NEVER MARRIED <input checked="" type="checkbox"/>		9. AGE (In years lost birthday) 82 yrs.	
10. DIVORCED <input checked="" type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Sunshine, Md. Mont. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Washington Cashell		14. MOTHER'S MAIDEN NAME Catherine Augusta Hobbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 219-12-4406	
17. INFORMANT Pauline Best		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) General Arteriosclerosis	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1965</u> to <u>6-8 1966</u> that (I) (we) last saw the deceased alive on <u>5-4 1966</u> , and that death occurred at <u>5:30 P.M.</u> from causes and on the date stated above.		22b. DATE SIGNED	
22c. SIGNATURE Morton Altschuler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Morton Altschuler		22d. ADDRESS 9205 New Hamp Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-11-66	
23c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel		23d. LOCATION (City or Town) (County) (State) Sunshine, Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Francis H. Barber Laytonsville	
25a. REC'D BY REGISTRAR DATE JUN 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08598

## CERTIFICATE OF DEATH

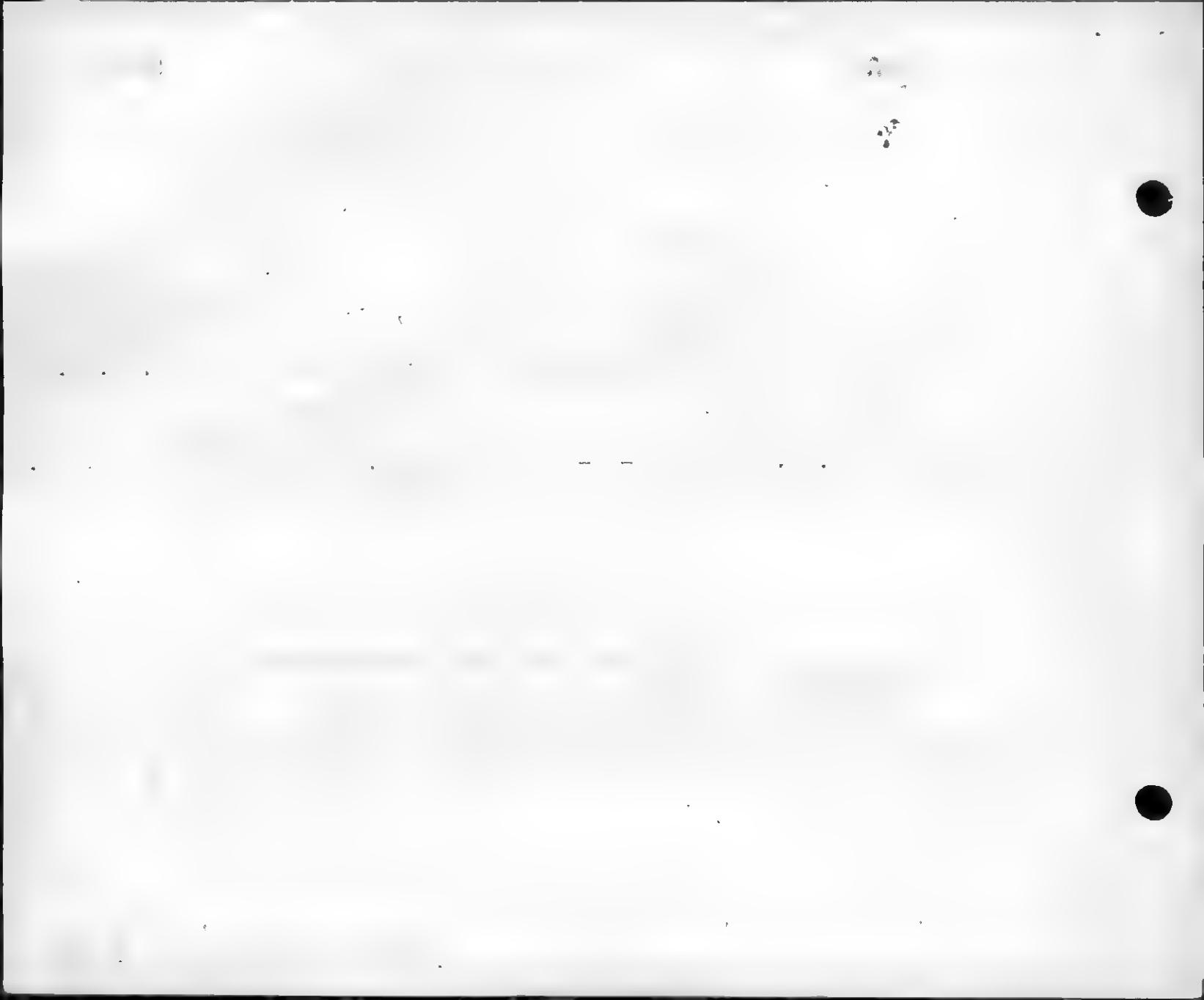
08588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5503 Newington Road</b>		d. STREET ADDRESS <b>5503 Newington Road</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>William</b> Middle <b>DUCHEZ</b> Last		4. DATE OF DEATH <b>JUNE 5 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1920</b>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>medical</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Denver, Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Charles DuChez</b>		14. MOTHER'S MAIDEN NAME <b>Rose Coulter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>yes</b>		16. SOCIAL SECURITY NO. <b>294-05-2840</b>	
17. INFORMANT <b>Mary V. DuChez</b>		Address <b>5503 Newington Rd Springfield, Md.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombus, rt coronary artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Coronary artery disease</b> DUE TO last (c) <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. (City or town) <b>(County)</b> <b>(State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>May 15, 1966</b> , to <b>Jun 5, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 15, 1966</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>6/5/66</b>	
22a. SIGNATURE <b>Jack Klett</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>JACK KLETT M.D.</b>		22d. ADDRESS <b>915 15th St. N.W. Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>June 6, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill</b>		23d. LOCATION (City or Town) <b>(County)</b> <b>(State)</b> <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawlers Sons 5130 Wisconsin Ave.</b>		25a. REC'D BY REGISTRAR <b>JUN 9 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

28598

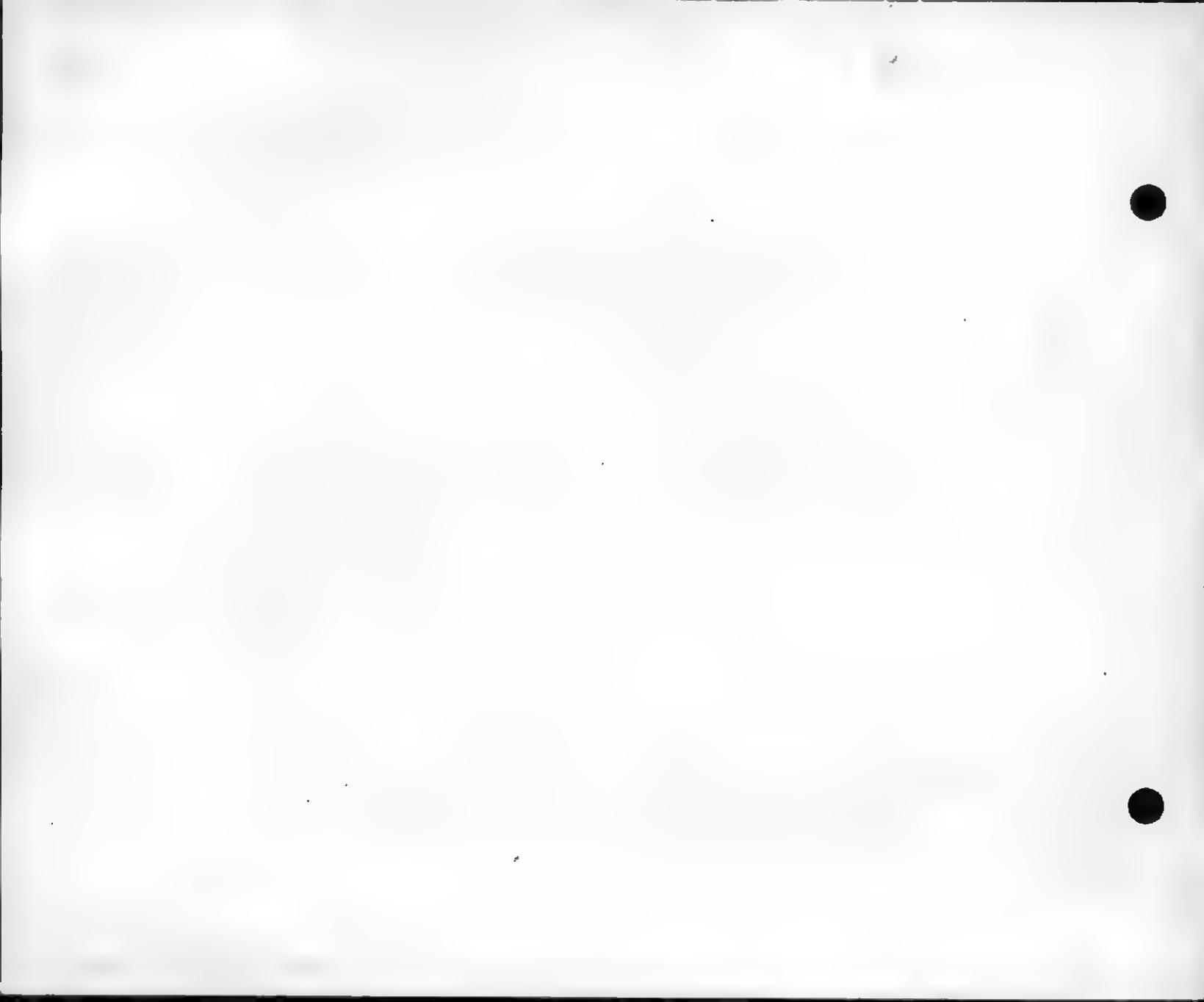
## CERTIFICATE OF DEATH

085589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b <b>1 MONTH</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>1606 TILTON DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>YETTA</b>	Middle <b>DUNKELMAN</b>	Last 4. DATE OF DEATH <b>JUNE 10, 1966</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 11, 1889</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>LATVIA</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>HYMAN KAHN</b>		14. MOTHER'S MAIDEN NAME <b>MIRIAM - KAHN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>SON</b> Address <b>LAWRENCE DUNKELMAN - 1606 TILTON DR.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis and calcification</b> DUE TO as the stenosis with left ventricular hypertrophy Year. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct.</b> , 1966, to <b>June</b> , 1966, that (I) (we) last saw the deceased alive on <b>June 9, 1966</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>June 10, 1966</b>	
22a. SIGNATURE <b>Sydney Leventhal</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Silver Spring, Md.</b>
22c. PHYSICIAN'S NAME <b>SYDNEY LEVENTHAL, M.D.</b>		23d. LOCATION (City, town or county) (State) <b>FALLS CHURCH, VA.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>
24. FUNERAL DIRECTOR <b>B. Danzansky &amp; Sons</b>		ADDRESS <b>3501-14th St. N. W. Wash. D.C.</b>	25a. REC'D BY REGISTRAR <b>JUN 14 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

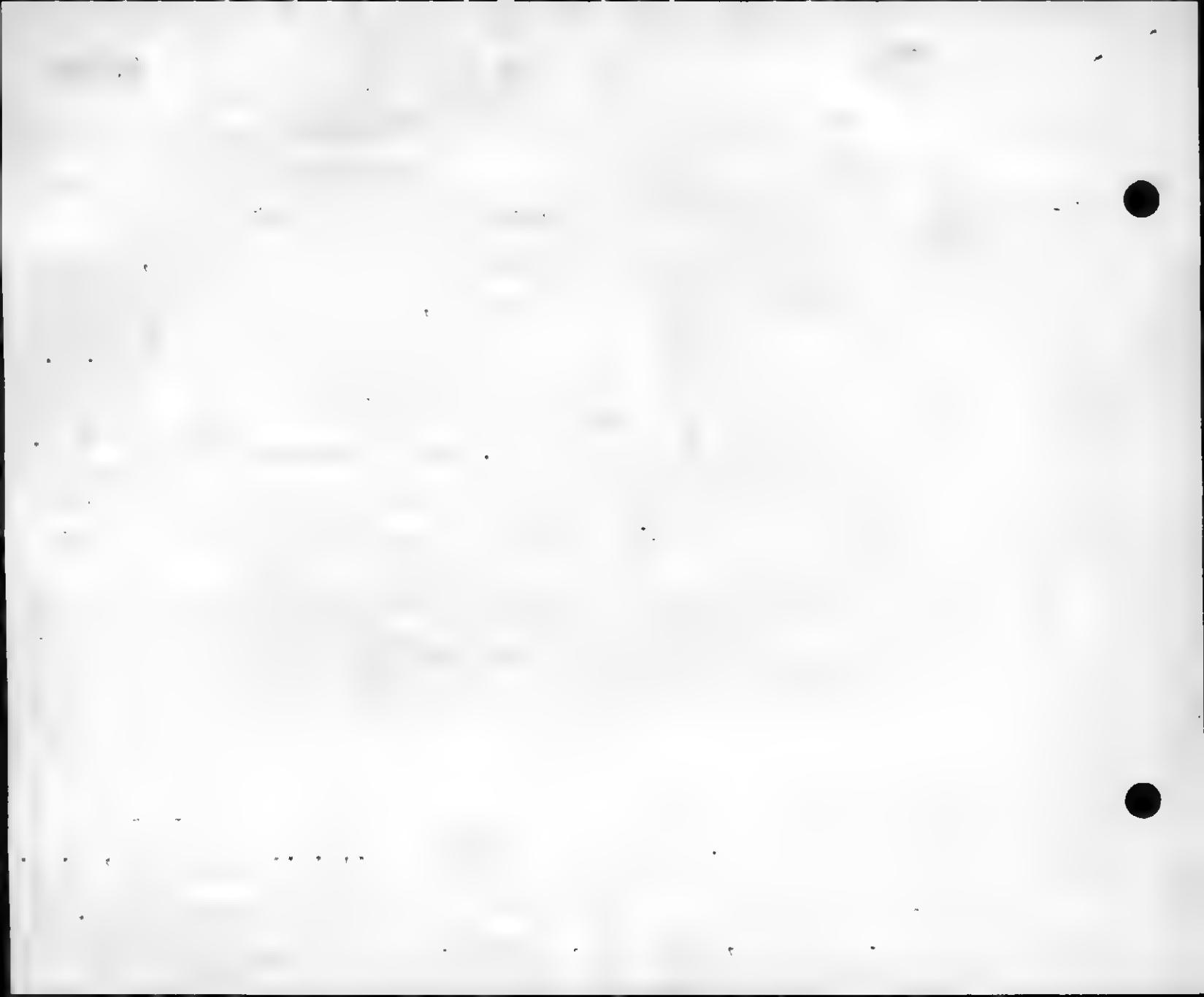


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 08600 08590

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 Week</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda Silver Spring Nursing Home</b>		d. STREET ADDRESS <b>5824 Ogden Court</b>		
3. NAME OF DECEASED (Type or print) <b>SARA SHEERIN</b>		First <b>SARA</b>	Middle <b>SHEERIN</b>	
4. DATE OF DEATH Month Day Year <b>June 15, 1966</b>		Last <b>DURBOROW</b>	Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1886</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>79 yrs.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Simon Sheerin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Doherty</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Sister</b>		Address <b>Mrs. Charles McCarthy</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <i>Cerebral thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>		
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis, generalized</i>		DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <b>30 April, 1966</b> , to <b>15 June, 1966</b> , that (I) (we) last saw the deceased alive on <b>15 June 1966</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>6-15-66</b>		
22a. SIGNATURE <i>Joseph J. Wallace</i>		22d. ADDRESS <b>1830 K St., N.W., Washington, D. C.</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH J. WALLACE</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 6-18-66</b>		
23b. DATE THEREOF <b>6-18-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Williamsport Cemetery</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		23d. LOCATION (City, town or county) <b>Williamsport, Ind.</b>		
ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR 25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE JUN 17 1966				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

**TO HOSPITAL:**  ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08601

08591

## 1. PLACE OF DEATH

## a. COUNTY

MONTGOMERY

## b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

CHEVY CHASE

## d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

7010 BEECHWOOD DRIVE

3. NAME OF DECEASED  
(Type or print)

First LEATHA

Middle M.

## 5. SEX

FEMALE

6. COLOR OR RACE  
WHITE

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (County &amp; State, or foreign country)

MAY 31, 1876

90

yrs.

0 8

Months Days Hours Min.

## 13. FATHER'S NAME

## 14. MOTHER'S MAIDEN NAME

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

## (Yes, no, or unknown) (If yes give rank or date of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

215-46-1878 MRS H. FOWLER

Address Same as Item 2.

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

4201

## DUE TO

ACUTE MYOCARDIAL INFARCTION

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

## (b)

ARTERIOSCLEROSIS CORONARY

## DUE TO

ARTERIES

## (c)

INTERVAL BETWEEN  
ONSET AND DEATH

8 hrs

## MEDICAL CERTIFICATION

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

GENERALIZED ARTERIOSCLEROSIS

20d. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour  
a.m.  
p.m.20d. INJURY OCCURRED  
While  
at work  
Not While  
at work  
at work20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that (I) (this hospital) attended the deceased from JAN 1958 to JUNE 8, 1966 that (I) (we) last saw the deceased alive on JUNE 8, 1966, and that death occurred at 11:30 AM the causes and on the date stated above.

## 22e. SIGNATURE

Lawrence A. RAPEE MD 1732 EYE ST. NW D.C.

23b. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (Specify)

Burial-transit 6-10-66

## 23c. NAME OF CEMETERY OR CREMATORIUM

## Hillside Cemetery

## 23d. LOCATION (City, town or county)

## Roslyn, Penna.

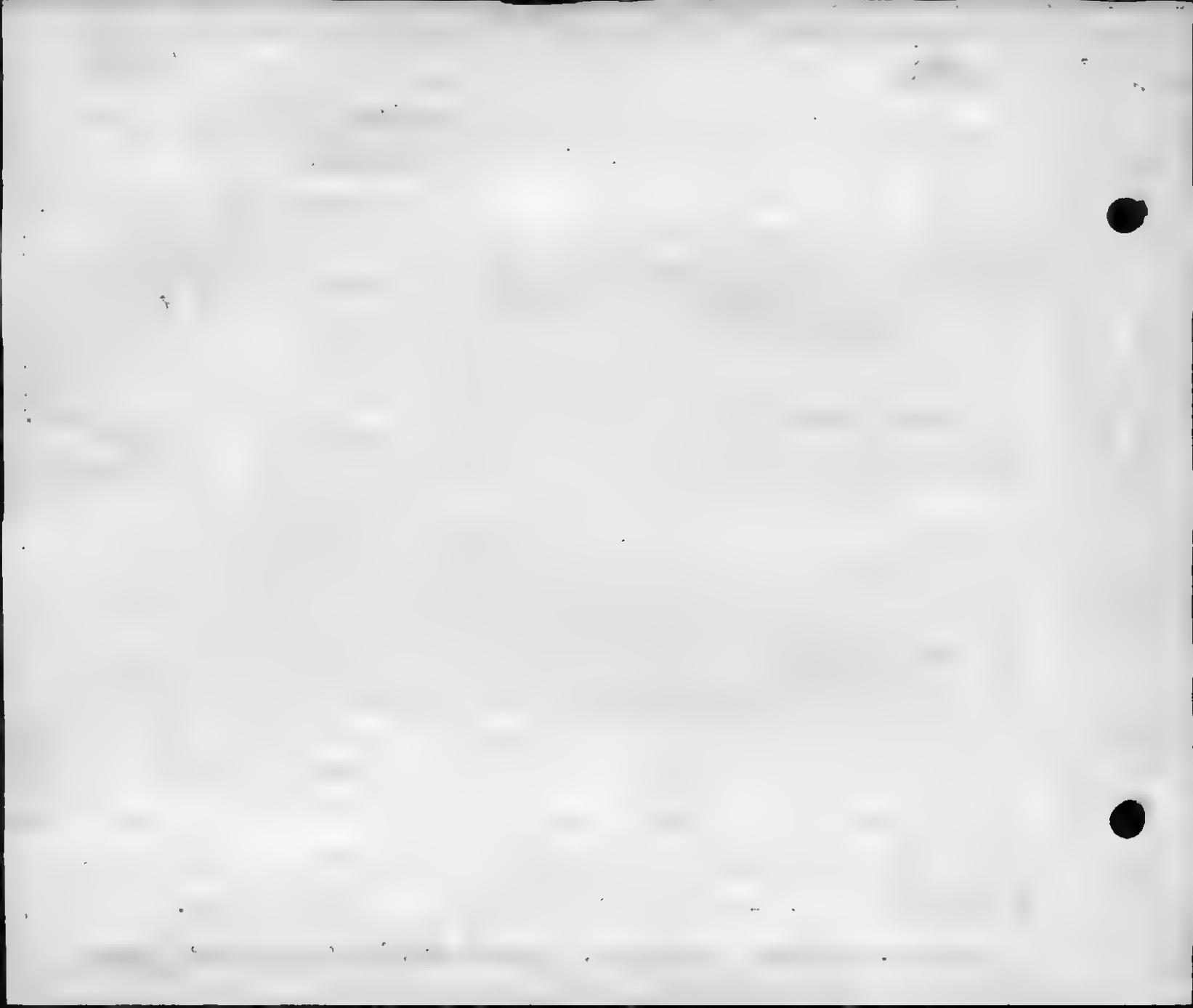
## (State)

## 24 FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY BETHESDA, MARYLAND JUN 13 1966

## 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Charles Judge



## MAX FERGUSON, SECRETARY OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00502

## CERTIFICATE OF DEATH

115592

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>DC</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		b. COUNTY	
c. LENGTH OF STAY IN 1b <b>2 1/2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wheaton Nursing Home</b>		d. STREET ADDRESS <b>2101 16th Street</b>	
3. NAME OF DECEASED (Type or print) <b>Rose</b>		4. DATE OF DEATH Last Month Day Year <b>Eicher June 14 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH b. B. DATE OF BIRTH <b>June 9, 1872</b>	
9. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Finance Div. War Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (County &amp; State or foreign country) <b>Ohio</b></b>	
12. CITIZEN OF WHAT COUNTRY <b>Pittsburg, Pa</b>		13. FATHER'S NAME <b>Joseph Eicher</b>	
14. MOTHER'S MAIDEN NAME <b>Rachel Nohn</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT <b>Mr. Myron M. Eicher-43 Seneca Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (his/her) attended the deceased from <b>Mar 1, 1961</b> to <b>June 14, 1966</b> that (I) (we) last saw the deceased alive on <b>June 13, 1966</b> and that death occurred at <b>4:30 PM</b> from the causes and on the date stated above.			
22. SIGNATURE <b>Francis P. Hannan</b>		22b. DATE SIGNED <b>June 14, 1966</b>	
22c. PHYSICIAN'S NAME <b>FRANCIS P. HANNAN, MD</b>		22d. ADDRESS ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>1511-17 ST. N.W. WASHINGTON, DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>6/17/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Homewood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pittsburgh, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The St. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>JUN 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

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STATE DEPARTMENT

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08503

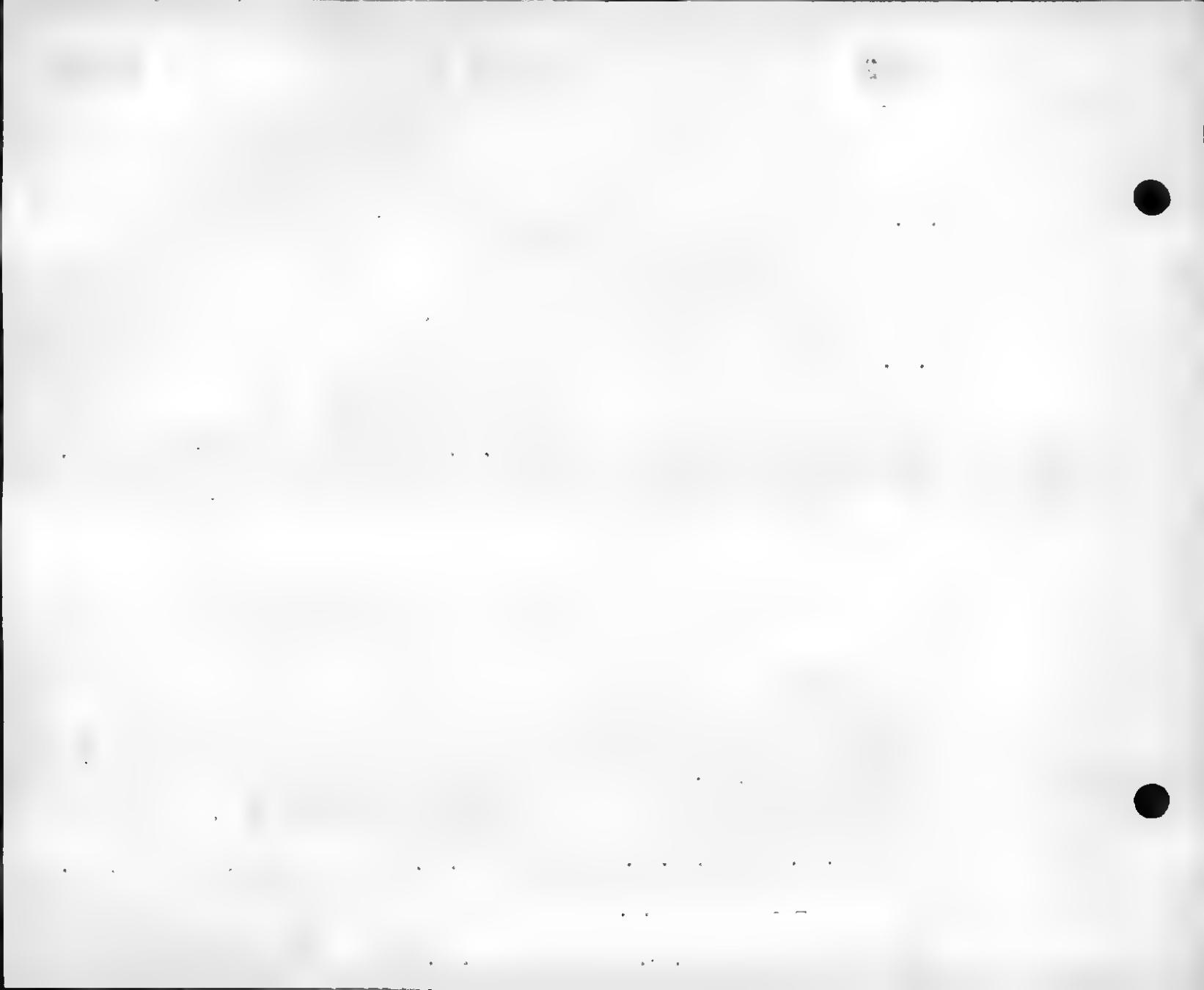
## CERTIFICATE OF DEATH

08593

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookdale	
c. LENGTH OF STAY IN 1b 34 days		d. STREET ADDRESS 4704 Overbrook Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norman Middle Wyatt Last ELLIS		4. DATE OF DEATH Month June Day 1 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 17, 1901		9. AGE (In years last birthday) 65 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Davison Ellis	
14. MOTHER'S MAIDEN NAME Georgia Clara Poole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1919-1954	
16. SOCIAL SECURITY NO 092-30-0469		17. INFORMANT Brookdale Address Maryland Mrs. M. Arline Ellis, 4704 Overbrook Rd./	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic adenocarcinoma of the sigmoid colon</u> INTERVAL BETWEEN ONSET AND DEATH 1033 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 28, 1966, to June 1, 1966, that (I) (we) last saw the deceased alive on June 1, 1966, and that death occurred at 510A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Charles</i>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1 June 1966	
22c. PHYSICIAN'S NAME (Type) D. K. Roeder, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-1966	
23c. NAME OF CEMETERY OR CEMATORIALY U.S. Naval Academy Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR Joseph Gawler & Sons 5130 Wisconsin Ave., N. W. Washington, D. C.		25a. NEED BY REGISTRAR ADDRESS DATE JUN 6 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

28604

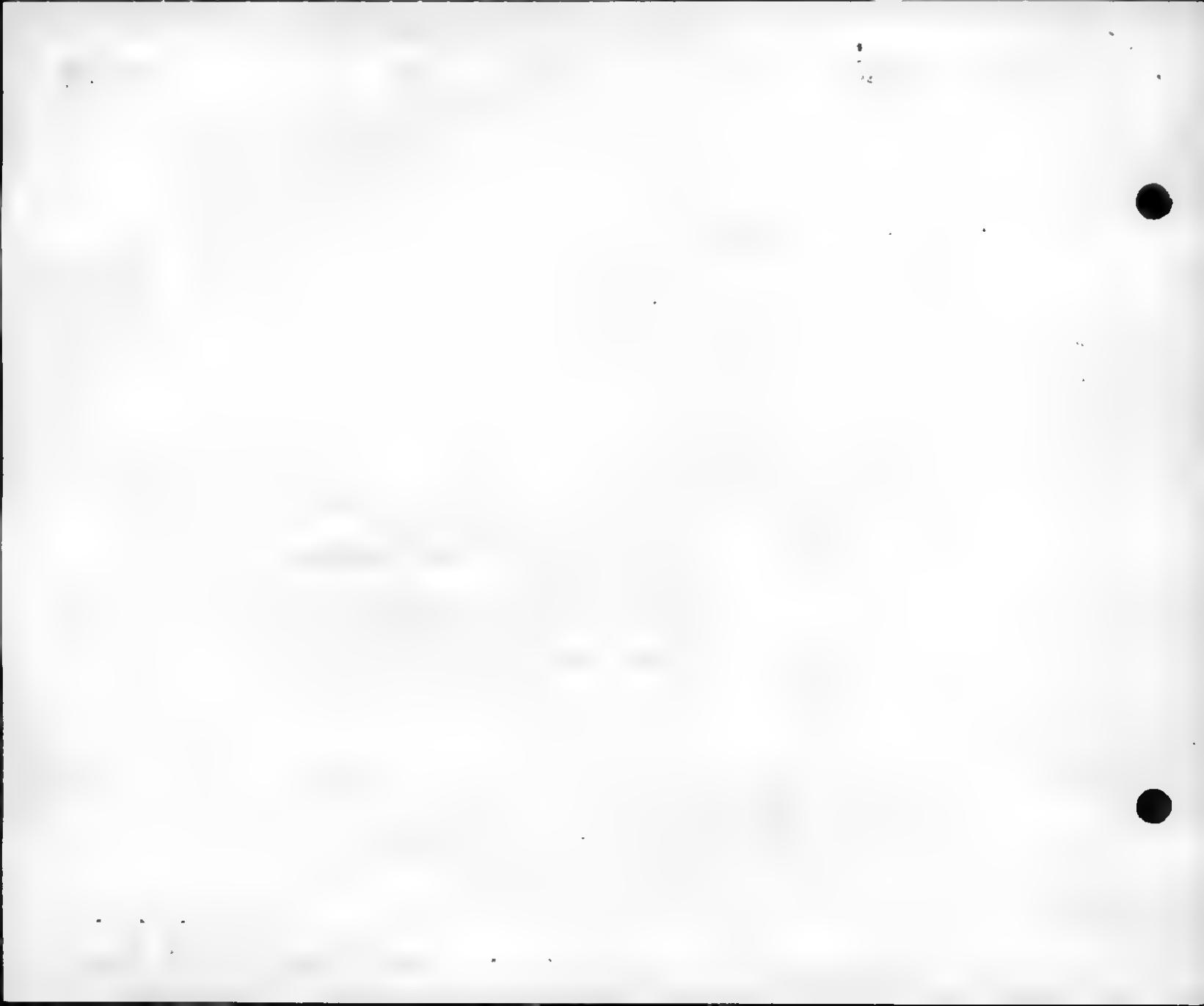
## CERTIFICATE OF DEATH

115594

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~sign~~ ~~initial~~ and file with the State Dept. of Health prior to burial, cremation, or removal, and an event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>411 Hull Place</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>JAMES</i>		First <i>James</i>	Middle <i>Manchester</i>	Last <i>Ellison</i>	4. DATE OF DEATH Month <i>June</i> Day <i>8</i> Year <i>1966</i>	Month <i>June</i>	Day <i>8</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1924</i>		9. AGE (in years last birthday) <i>41</i> yrs	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Minutes <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MUSIC Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>St Louis -</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William Ellison</i>		14. MOTHER'S MAIDEN NAME <i>Constance Manchester -</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>579-22-8895</i>		17. INFORMANT <i>Wife</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <i>4301</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost.		Major cardiac infarction		INTERVAL BETWEEN ONSET AND DEATH <i>0</i>				
(b) DUE TO		Cerebral arteriosclerosis, severe		Cerebral				
(c) DUE TO		Emphysema		Emphysema				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. - 19 p.m. -		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>4/26, 1966</i> to <i>4/8, 1966</i> that (I) (we) last saw the deceased alive on <i>4/7/66</i> 1966, and that death occurred at <i>2:00 A.M.</i> from causes and on the date stated above.								
22a. SIGNATURE <i>Robert R. Montgomery</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <i>June 8, 1966</i>		
22c. PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>		22d. ADDRESS <i>5411 CEDAR Lane Bethesda, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-11-66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Md.</i>		25a. RECD BY REGISTRAR <i>JUN 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 15, 17 Film 3782531 mh

## CERTIFICATE OF DEATH

05595

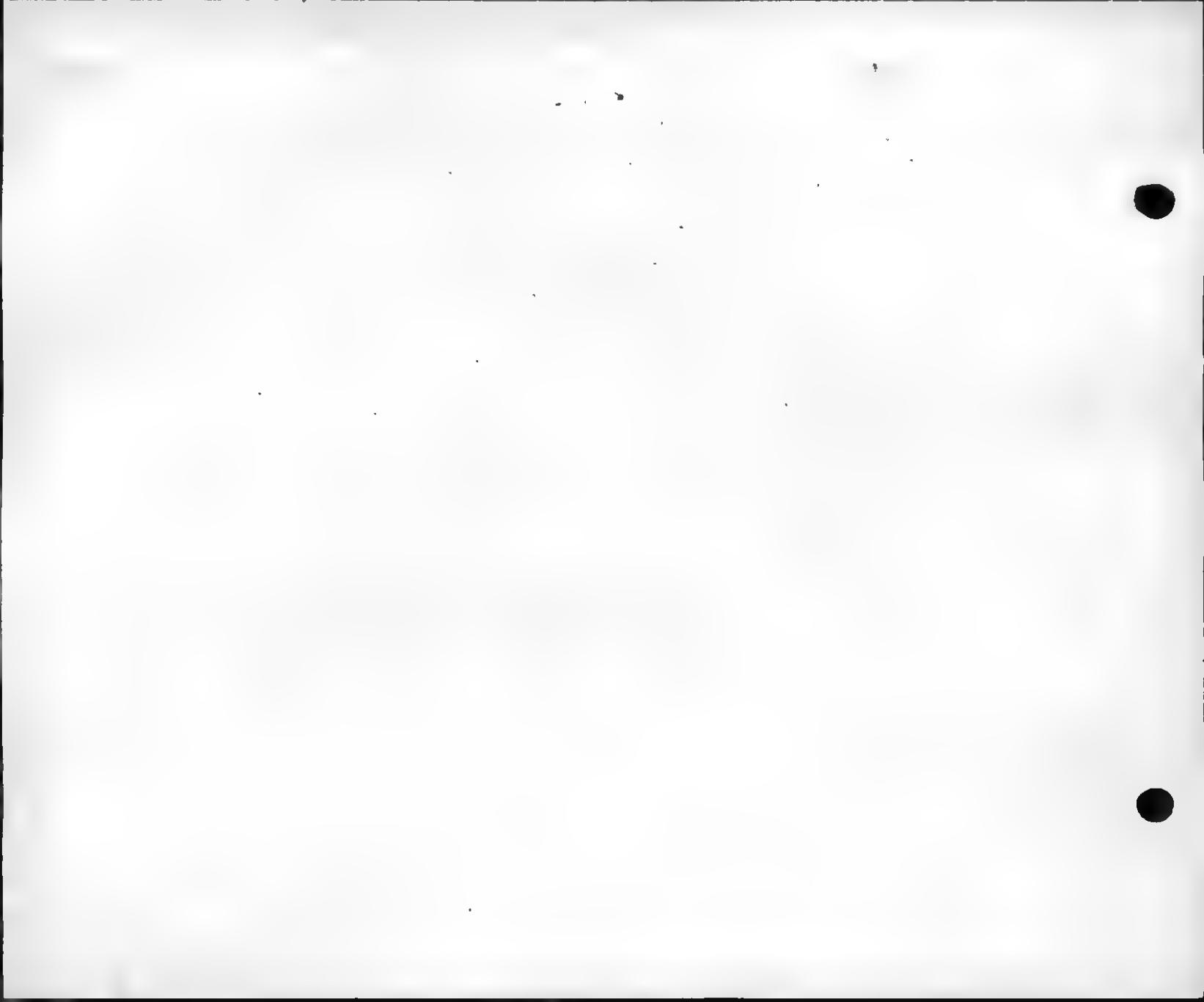
1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~stamped~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22605

1 PLACE OF DEATH a COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery Maryland		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Bethesda		Mont.	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
6 moa		Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Suburban		8409 Farrell Dr	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
Jonathan Bentley Epstein		6-26 1966	
5. SEX		6. COLOR OR RACE	
m		7. MARRIED	
WIDOWED		NEVER MARRIED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs	
6-21-66		5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (County & State, or foreign country)	
		WASH. D.C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.A.		Howard Epstein	
14. MOTHER'S MARRIED NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
Carol Benjamin		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Father - Howard Epstein	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Subarachnoid hemorrhage			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/21/66 to 6/26/66, that (I) (we) last saw the deceased alive on 6/25/66, and that death occurred at 238 M, from causes and on the date stated above		22b. DATE SIGNED	
22a. SIGNATURE		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
William N. Sterling M.D.		22d. ADDRESS	
22c. PHYSICIAN'S NAME (Type)		4700 Braddock Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-28-66	
23c. NAME OF CEMETERY OR CREMATORIAL Kingsview Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Faith Church V.F.F.	
24. FUNERAL DIRECTOR B. Daunovsky & Sons 3501-14th NW		25a. REC'D BY REGISTRAR JUN 30 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

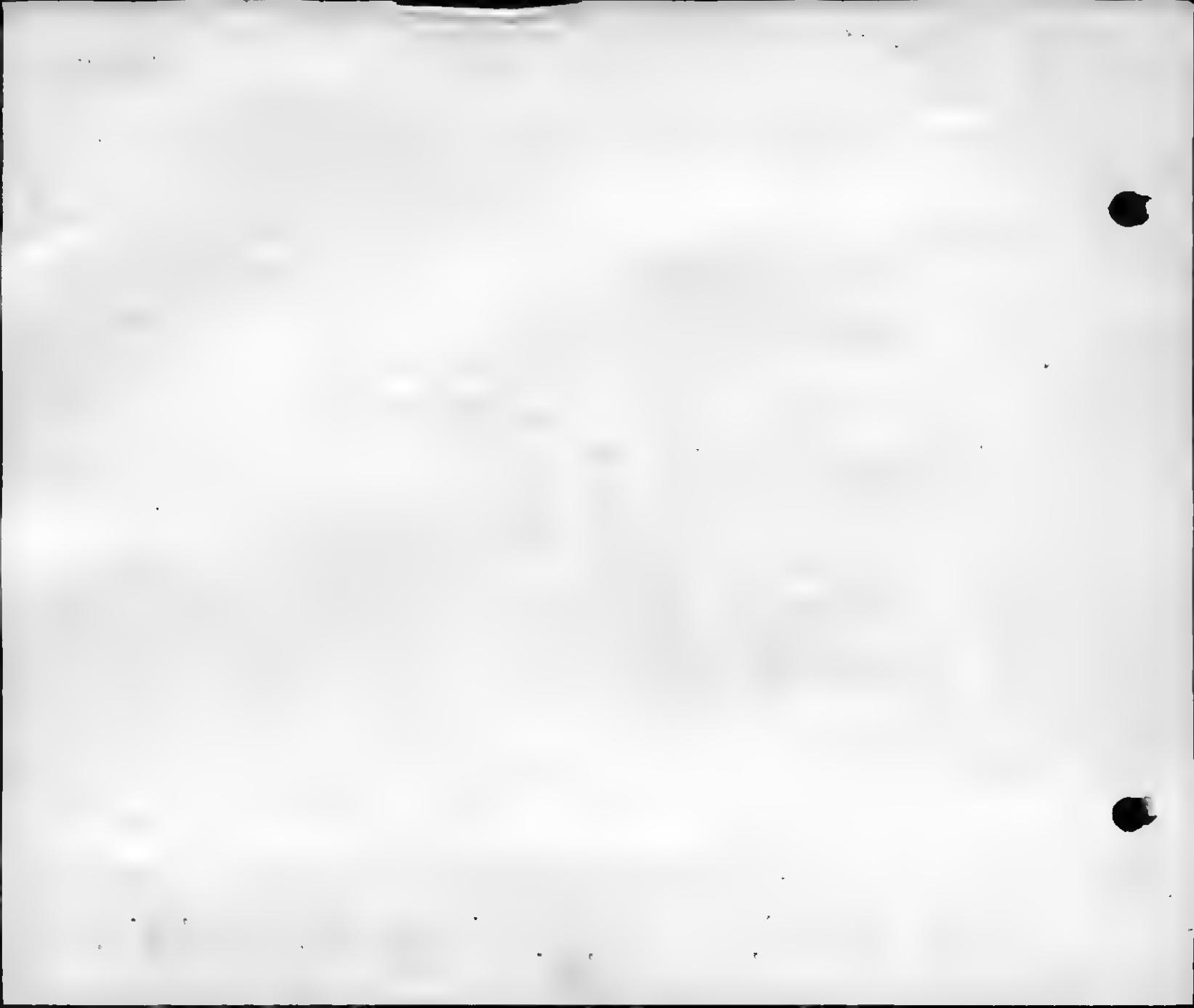
08596

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery		Rural - Damascus		Life		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b. MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Rural - Damascus		Life		Rural - Damascus (Clagettsville)		Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
Route 80 - Germantown Rd.		Route 80		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print)		First		Middle		4. DATE OF DEATH	
Annie		May		Esworthy		June 15 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 19, 1901	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		None		Montgomery Co, Md		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
Louis Benjamin Easton		Laura Catherine Moxley		John Esworthy, Clagettsville			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
No		215-03-6139		John Esworthy, Clagettsville		1 week	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage			
		DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
		DUE TO { cause last.		(c)			
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Hypertensive Cardiovascular Disease		10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
				19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from ... July 1964, to ... June 1966, that (I) (we) last saw the deceased alive on ... June 12, 1966, and that death occurred at 5 A.M. from the causes and on the date stated above		22e. SIGNATURE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		W.B. Easton		22d. ADDRESS		June 15, 1966	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
Burial		June 18, 1966		Montgomery Meth.		Clagettsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Olin L. Molesworth,		Damascus, Md.		JUN 20 1966		Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08507

## CERTIFICATE OF DEATH

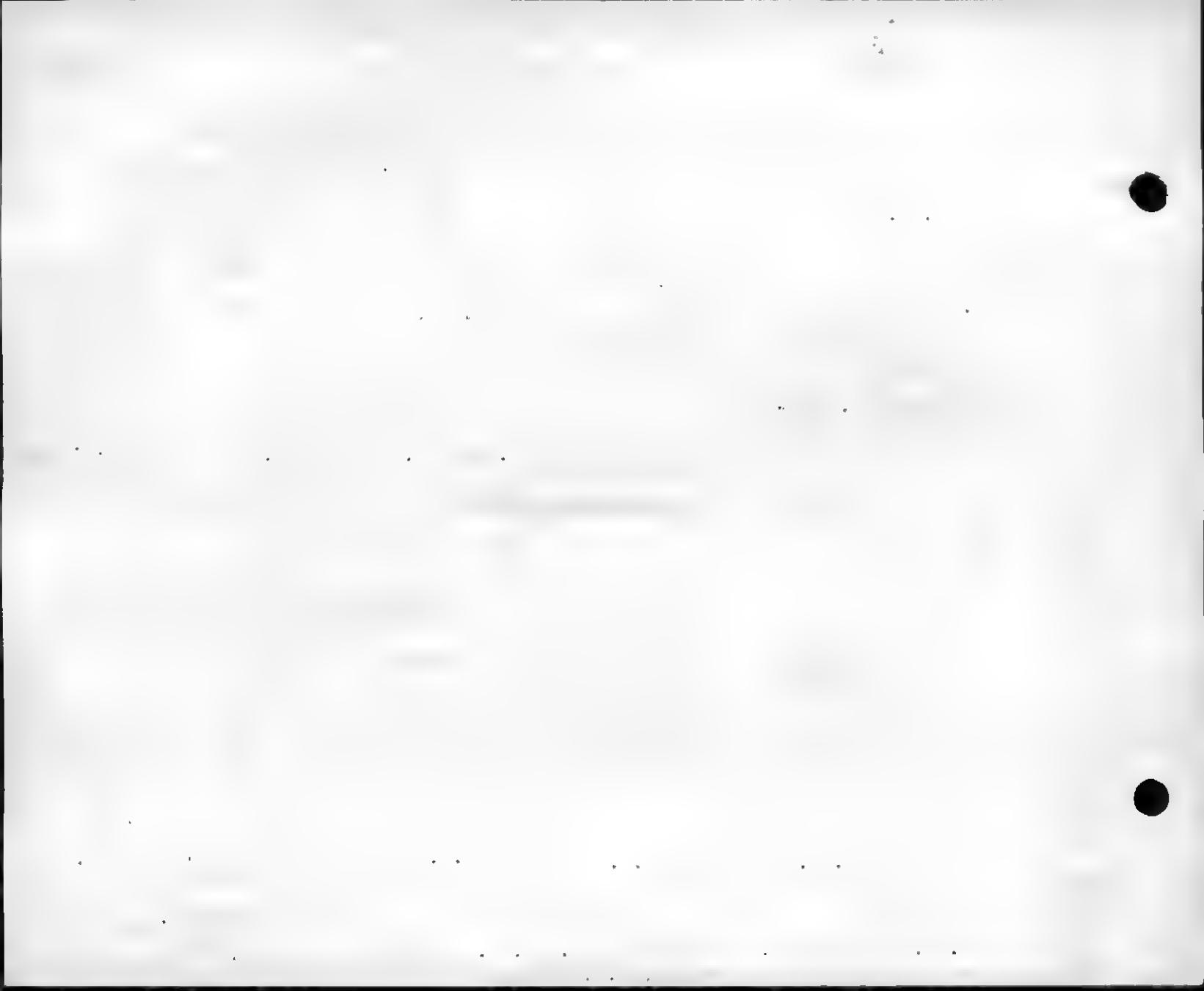
08597

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 9 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverview Village, Indian Head				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS Apartment 7G		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Wilma		First	Middle	Lost	4. DATE OF DEATH June 9	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1919	9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) Lyons, Kansas		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Raymond L. Foster				14. MOTHER'S MAIDEN NAME -Beth Bertha Johnston				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 546-14-2226		17. INFORMANT age, Indian Head Address Mr. John E. Ewing, Apt. 7G, Riverview Vill-				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 170X		DUE TO		Widespread Metastatic Adeno Carcinoma of Breast		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (s) (this hospital) attended the deceased from June 9, 1966, to June 9, 1966, that (s) (we) last saw the deceased alive on June 9, 1966, and that death occurred at 555A.M., from causes and on the date stated above.						22b. DATE SIGNED 10 June 1966		
22a. SIGNATURE J. E. ZIMMERMAN, M.D.		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) J. E. ZIMMERMAN, M.D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF JUN 13 1966		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.		
24. FUNERAL DIRECTOR W. W. Chambers Co., 1400 Chapin St., N. W. Washington, D.C.		ADDRESS		25a. REC'D. BY REGISTRAR JUN 14 1966		25b. REGISTRAR'S SIGNATURE Charles J. J.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)									
a. COUNTY <i>Montgomery</i>			b. STATE <i>Maryland</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>6 years and 8 mos.</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Althea Woodsland Nursing Home</i>			e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
3. NAME OF DECEASED (Type or print)			First <i>Martha</i>	Middle <i>Ellen</i>	Last <i>Farley</i>	4. DATE OF DEATH <i>12/11/1886</i>	Month <i>6</i>	Day <i>29</i>	Year <i>1966</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12/11/1886</i>		9. AGE (in years last birthday) <i>79 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>John Gibson</i>	
14. MOTHER'S MAIDEN NAME <i>Anne Hardler</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>No None</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Martha Macht</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i> DUE TO <i>Arthritis, coronary</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Address <i>3900 North Charles St. Baltimore, Maryland</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
19												
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , 19, to <i>6/29/66</i> , 19, that (I) (we) last saw the deceased alive on <i>4/10/66</i> , 19, and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.												
22a. SIGNATURE <i>A. W. Smith</i>												
22c. PHYSICIAN'S NAME (Type) <i>A. W. SMITH</i>			22b. DATE SIGNED <i>6/29/66</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>July 1, 1966</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR <i>John B. Thomas</i>			ADDRESS <i>8434 Georgia Ave.</i>			25a. REC'D BY REGISTRAR <i>JUL 5 1966</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
Warren E. Pumphrey, Inc.			Silver Spring, Md.									



1  
FOR STATE  
HEALTH DEPT.

08609

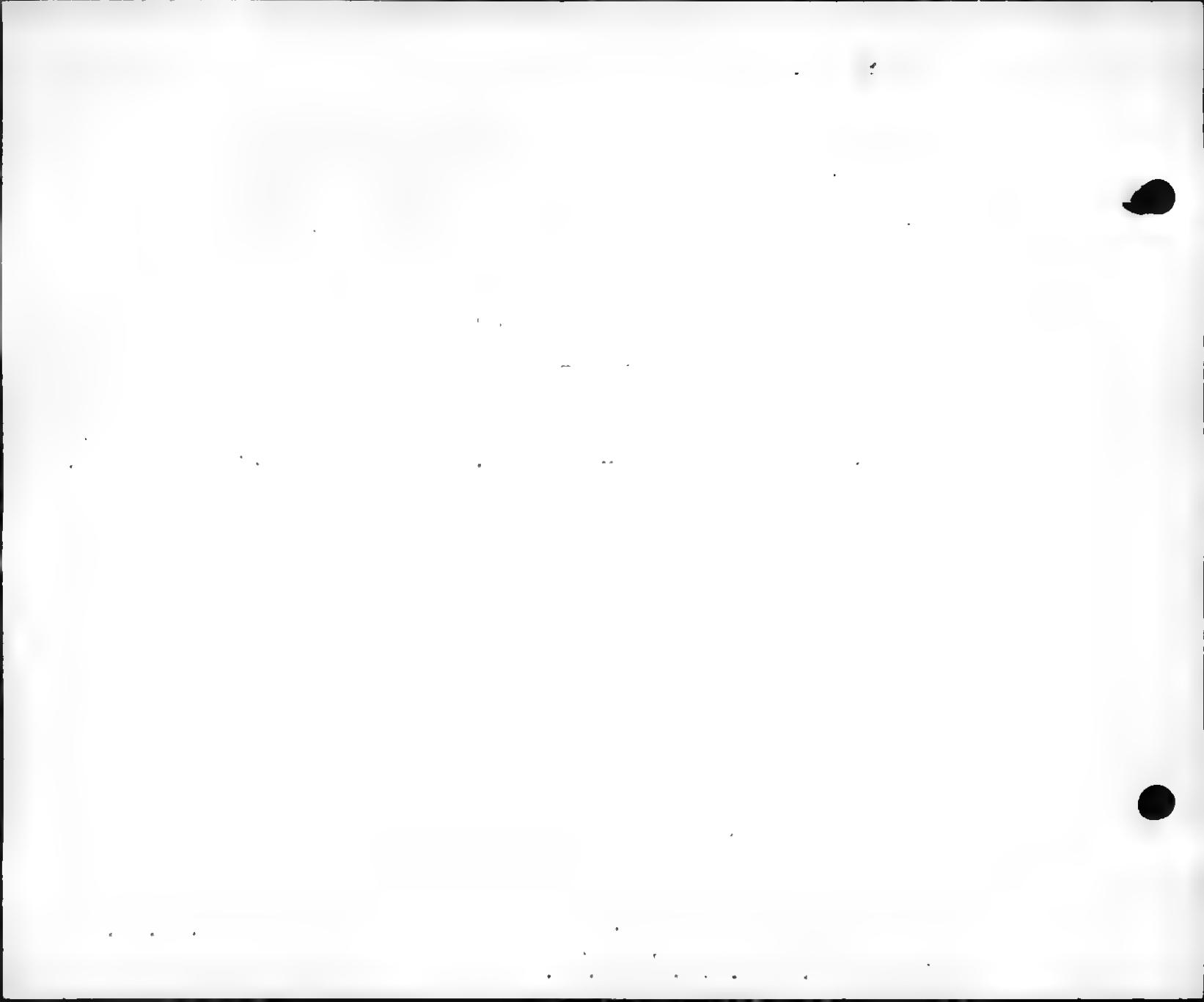
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08599

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a STATE <b>District of Columbia</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 2½ days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d STREET ADDRESS <b>5122 New Hampshire Avenue</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Franklin</b>		First	Middle
4. DATE OF DEATH	Month	Day	Year
<b>Farrell</b>	<b>June</b>	<b>30</b>	<b>1966</b>
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1904</b>
9 AGE (In years last birthday) <b>62</b>	10. SOCIAL SECURITY NO <b>578-48-2156</b>	11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Benjamin Farrell</b>		14. MOTHER'S MAIDEN NAME - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -		16. SOCIAL SECURITY NO <b>14704 Elissa Drive, Rockville, Md.</b>	
17. INFORMANT <b>Mrs. Patricia Foster;</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>7/25</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		Fat embolization to brain, lungs, and kidneys due to fractured right ischium.	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased fell down stairway at home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour AM <b>5:30 p.m. 6/25 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Washington</b>		(County) (State) <b>D. C.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <b>Charlton</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-2-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mr. Olivet Cemetery</b>
23d. LOCATION (City or Town) <b>Washington</b>		(County) (State) <b>D. C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. DC.</b>	25b. REC'D BY REGISTRAR DATE JUL 5 1966
		REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08630

## CERTIFICATE OF DEATH

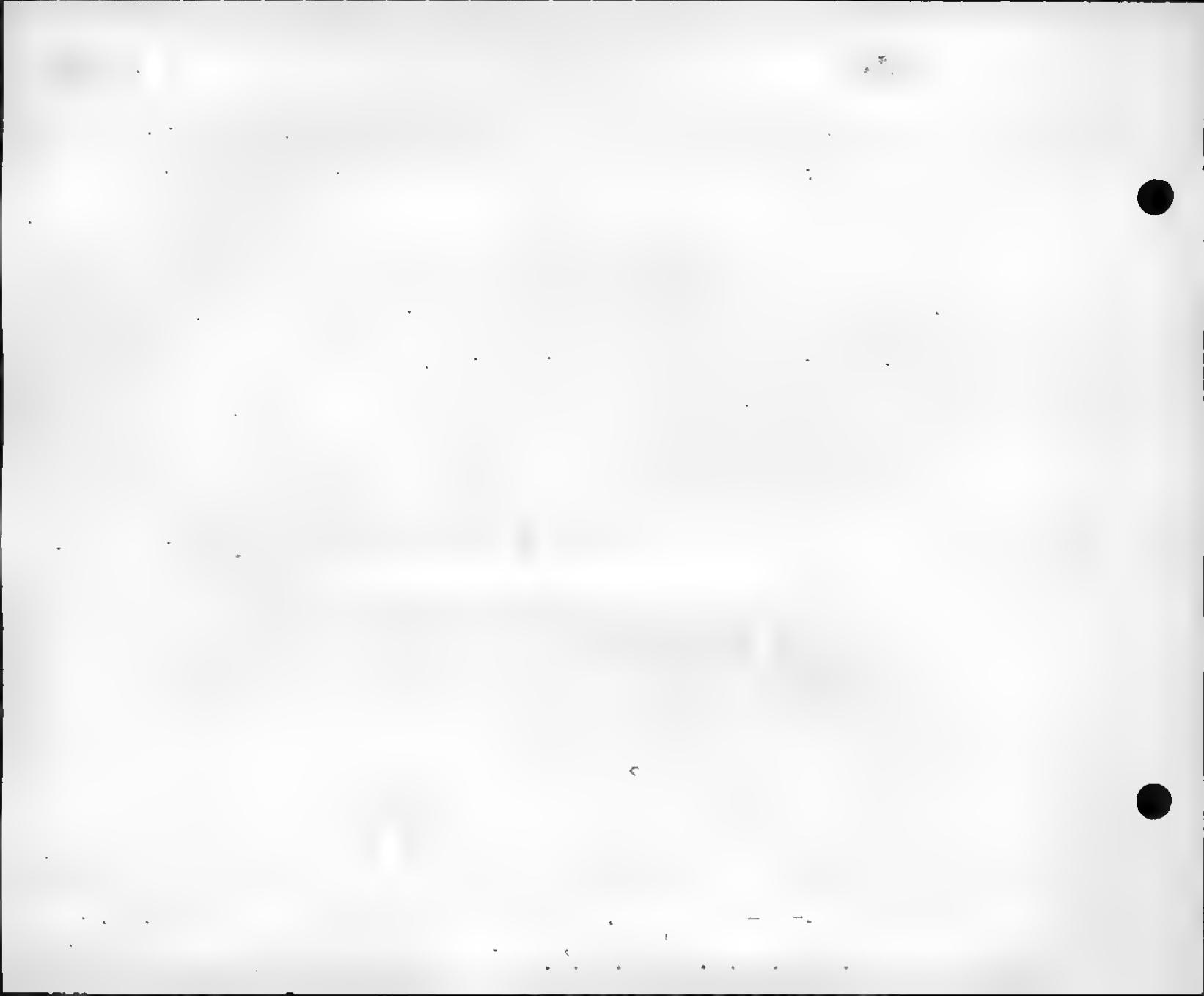
08600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>4701 - Connecticut Ave NW</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rensington Md.</i>		b. COUNTY <i>Washington - D C</i>	
c. LENGTH OF STAY IN 3b <i>5/1/65 to 6/2/66</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington - D C</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens Sanatorium.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Helen Isabel FARRELL</i>		4. DATE OF DEATH <i>6/8/66</i>	Month <i>JUNE</i>
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>WV.</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>Jan-28-1886</i>		9. AGE (in years last birthday) <i>80</i>	FUNDED 1. YEAR Months <i>5</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>-</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (County & State, or foreign country) <i>VERMONT</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>Patrick FARRELL.</i>	
14. MOTHER'S MAIDEN NAME <i>SARAH Brady</i>		15. INFORMANT <i>(S. C.R.) Mrs OTTO Ruppert</i>	
16. SOCIAL SECURITY NO <i>- - -</i>		17. ADDRESS <i>6118-Offutt Rd</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c) <i>-</i>		DUE TO <i>Cerebral arteriosclerosis and coronary arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>June 28 1966 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <i>-</i>
20f. (City or town) <i>-</i>		(County) <i>-</i>	
(State) <i>-</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (This hospital) attended the deceased from <i>June 28 1966</i> , to <i>June 28 1966</i> , that (I) (we) last saw the deceased alive on <i>June 28 1966</i> , and that death occurred at <i>5:15 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>June 28, 1966</i>	
22a. SIGNATURE <i>Joseph J. McCarthy, Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>JOSEPH J. McCARTHY, JR. M.D.</i>		22d. ADDRESS <i>3001 Q ST. N.W., WASHINGTON DC 20007</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-30-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Olivet Cemetery</i>
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.		25a. RECEIVED BY REGISTRAR DATE <i>JUL 5 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

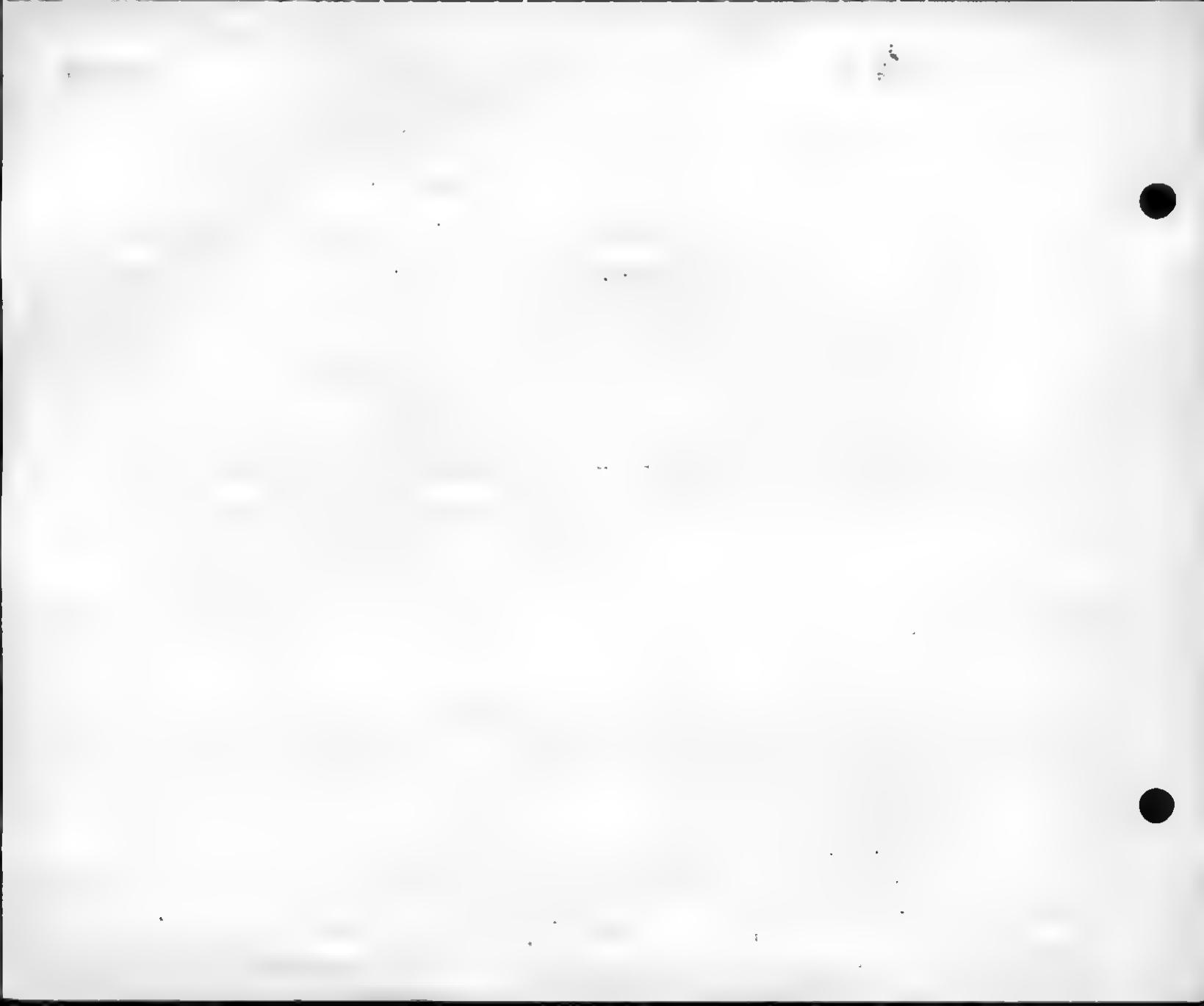
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08611

## CERTIFICATE OF DEATH

08601

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>1 day 15 1/2 hrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		e. STREET ADDRESS <i>2005 Brighton Road</i>	
3. NAME OF DECEASED (Type or print) <i>Donald</i>		First <i>Arthur</i>	Middle <i>Fisher</i>
4. DATE OF DEATH Month <i>6</i>	Month <i>21</i>	Day <i>1966</i>	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>5-29-08</i>
9. AGE (In years last birthday) <i>58 yrs</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cab Driver</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>West Virginia</i>
12. FATHER'S NAME <i>Arthur Fisher</i>	13. MOTHER'S MAIDEN NAME <i>LeLia Price</i>	14. CITIZEN OF WHAT COUNTRY? <i>America</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>none</i>	16. SOCIAL SECURITY NO. <i>578-05-3000</i>	17. INFORMANT <i>Patient's Chart</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
CVA - occlusion of post. inf. cerebellar artery		12 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6/10</i> , 1966, to <i>6/21</i> , 1966, that (I) (we) last saw the deceased alive on <i>6/20</i> , 1966, and that death occurred at <i>2:30 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Hugh W. Irey</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Hugh W. Irey</i>	22d. ADDRESS <i>7105 - RIGGS RD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/23/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Suitland, Md.</i>
24. FUNERAL DIRECTOR Home Inc.	Nalley's Funeral Home Inc.	25a. REC'D BY REGISTRAR T. Rainier Maryland	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08612

CERTIFICATE OF DEATH

08602

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Washington, D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b <i>10 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>11</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. and Hospital</i>		d. STREET ADDRESS <i>5820 22nd Avenue, S.E.</i>	
3. NAME OF DECEASED (Type or print) <i>Carl Edward Flank</i>		4. DATE OF DEATH <i>June 23 1966</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-2-98</i>	
9. AGED (In years last birthday) <i>68 yrs.</i>		10. IF UNDER 1 YEAR Months Dey. Hours Min. <i>12. CITIZEN OF WHAT COUNTRY?</i> <i>Amer.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Record - Washington San. + Hosp. Takoma Park</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Sweden</i>		14. MOTHER'S MAIDEN NAME <i>Christian Anderson</i>	
13. FATHER'S NAME <i>John Flank</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give name and dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Address</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> )	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stalling the underlying } (b) cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
Cerebral infarction		Cerebral thrombosis	
Cerebral thrombosis		Arteriosclerosis obliterans	
Arteriosclerosis obliterans		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20e. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6/13 1966</i>		20f. (City or town) (County) (State) <i>Suitland Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from ... to ... , 19 ... , that (I) (we) last saw the deceased alive on ... to ... , 19 ... , and that death occurred at ... M, from the causes and on the date stated above		22b. DATE SIGNED	
22e. SIGNATURE <i>Blanche Cray</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Blanche Cray</i>		22d. ADDRESS <i>M.D.</i>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>Burial</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>	
23d. LOCATION (City, town or county) <i>Suitland Maryland</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Wilhelm Funeral Home		25e. REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS Maryland 4309 Suitland Rd Suitland DATE JUN 27 1966 J Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

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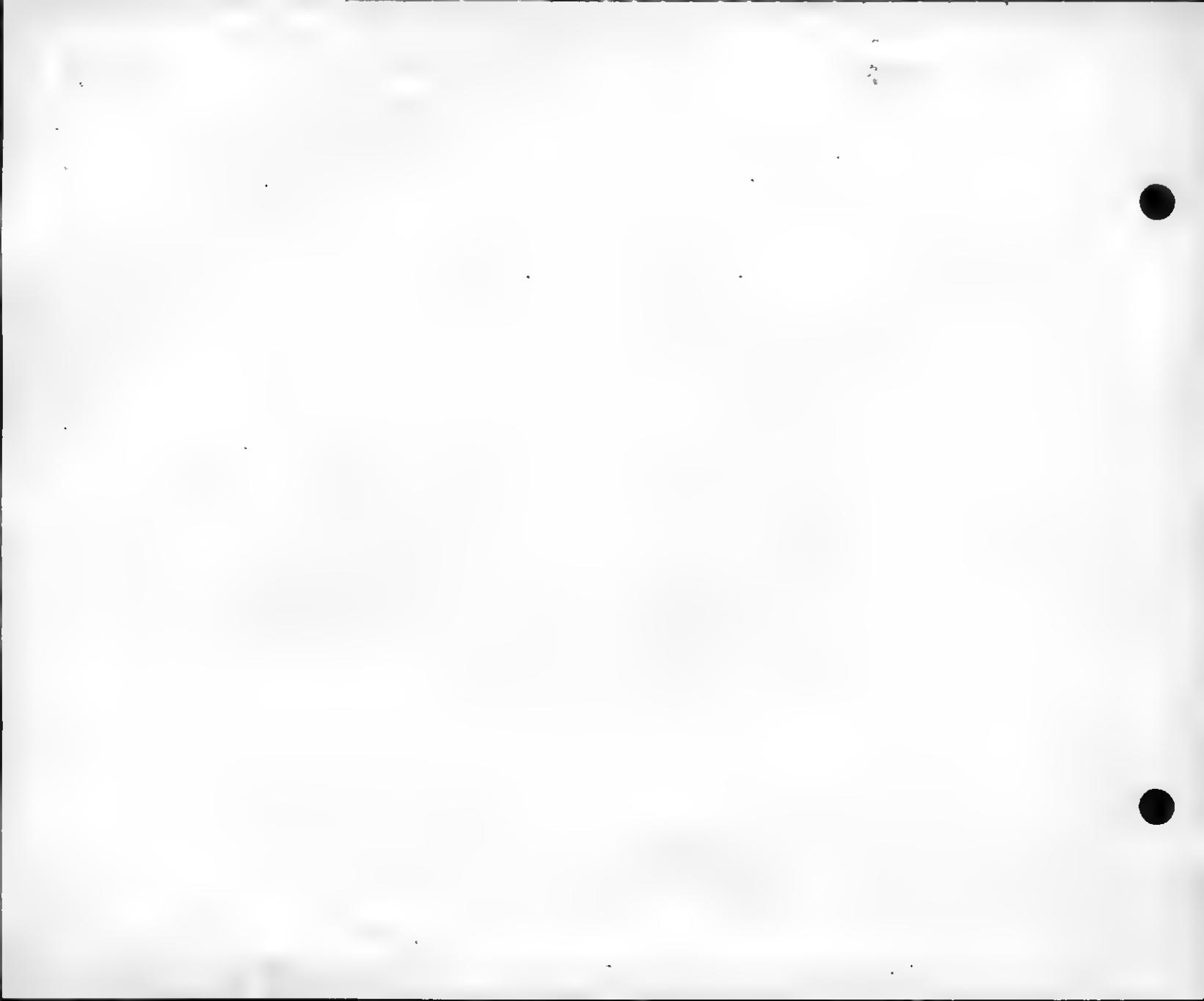
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08613

## CERTIFICATE OF DEATH

08603

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>D.O.A</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>121 Indian Spring Dr.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HARRIET Elizabeth FLYNN</i>		4. DATE OF DEATH <i>JUNE 27 1966</i>	Month Day Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
9. B. DATE OF BIRTH <i>MAY-1-1881</i>		10. AGE (In years, months, days, birth month, birth day, birth year) <i>85 yrs</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>FAIRFAX Co. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HENRY GARNER</i>		14. MOTHER'S MAIDEN NAME <i>THEDA Read</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>House wife</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Katherine Lindgreen</i> (Daughter) Address <i>121 Indian Spring Dr.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <i>arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1956</i> , 19, to <i>26 June</i> , 1966, that (I) (we) last saw the deceased alive on <i>26 May</i> , 1966, and that death occurred at <i>3:30 A.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>John M. Wyman</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6/27/66</i>
22c. PHYSICIAN'S NAME (Type) <i>John M. Wyman</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/29/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Fairfax Cemetery</i>
24. FUNERAL DIRECTOR <i>David W. Grindall</i>		25a. REC'D BY REGISTRAR Everly Funeral Home	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE  
HEALTH DEPT.

**CHIEF MEDICAL EXAMINER:** This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

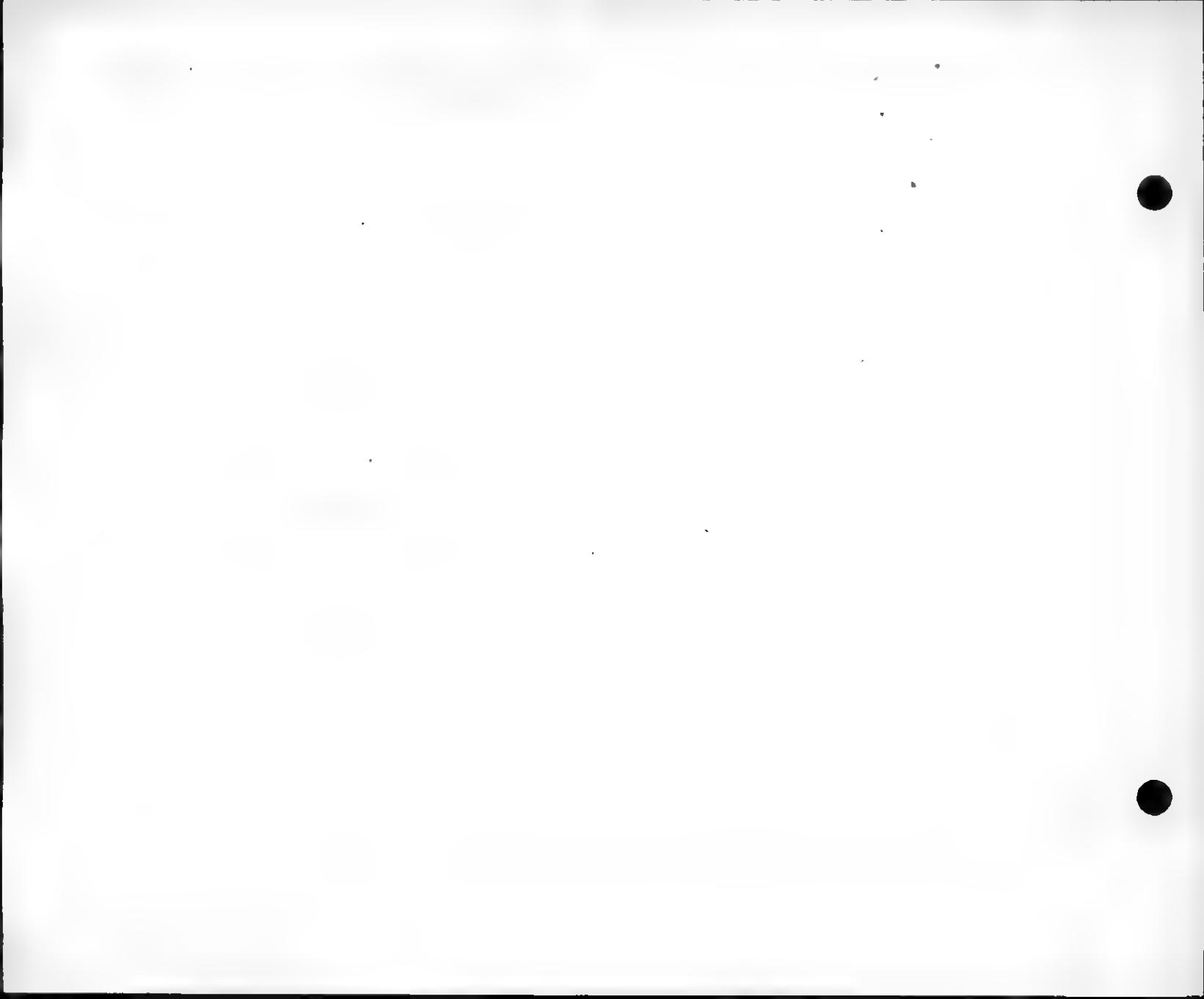
**NO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08604

<p>1. PLACE OF DEATH a. COUNTY <b>Montgomery</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beacon Park</b></p> <p>c. LENGTH OF STAY IN lb</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <b>Wash San + Hospital</b></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b></p> <p>b. COUNTY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b></p> <p>d. STREET ADDRESS <b>2908-30th St. SE. #7</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print)</p> <p>First: <b>Benjamin</b> Middle: <b>Brasington</b> Last: <b>Forte</b></p>				<p>4. DATE OF DEATH Month: <b>6</b> Day: <b>25</b> Year: <b>1966</b></p>			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-9-03</b>	9. AGE (In years from last birthday) <b>62</b> yrs	10. IF UNDER 1 YEAR Months: <b>0</b> Days: <b>0</b> Hours: <b>0</b> Min: <b>0</b>	11. IF UNDER 24 HRS.
<p>10a. US-AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EDITOR-USIA</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Camden S.C.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>OLIVER M. FORTE</b></p>				<p>14. MOTHER'S MARRIED NAME <b>Sally Mickle</b></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b></p>		<p>16. SOCIAL SECURITY NO</p>		<p>17. INFORMANT <b>Mrs Emery Forte (wife)</b></p>		<p>Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for Part I, (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Acute Coronary Insufficiency</b></p>						<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DUE TO (b) DUE TO (c) <b>Coronary Artery Heart Disease.</b></p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <b>Belden R. Reap</b></p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town, or county) <b>Camden, S.C.</b></p>			
<p>22. DATE SIGNED <b>6/26/1966</b></p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Quaker Cem</b></p>		<p>23b. DATE THEREOF <b>9/27/66</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>WASH. D.C.</b></p>		<p>23d. LOCATION (City or Town) (County) (State)</p>	
<p>24. FUNERAL DIRECTOR <b>W.W. Chambers, 517 1/2 ST SE.</b></p>				<p>25a. REC'D BY REGISTRAR DATE <b>JUL 1 1966</b></p>		<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

38615

## CERTIFICATE OF DEATH

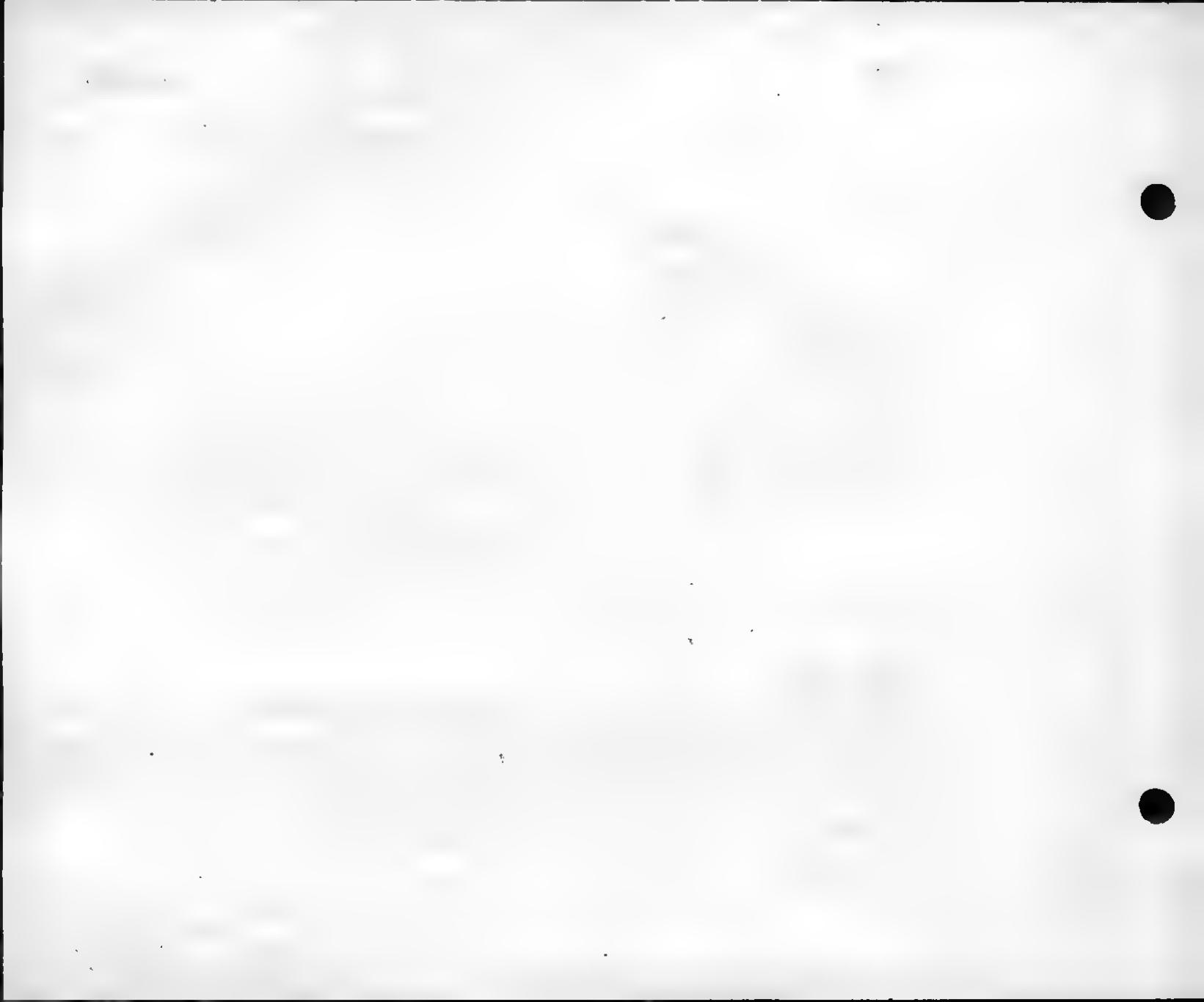
08605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>CARROLL HALL SANITARIUM</i>		d. STREET ADDRESS <i>107 Hesketh Street</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Anna A.</i>		First <i>Anna</i>	Middle <i>A.</i>			
4. DATE OF DEATH Month <i>JUNE</i>	Month <i>10</i>	Day <i>1966</i>	Year			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>			
8. B. DATE OF BIRTH <i>10-30-1882</i>	9. AGE (In years at 1st birthday) <i>83</i>	10. IF UNDER 1 YEAR Months <i>83</i>	11. IF UNDER 24 HRS Days <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <i>Norway</i>				
13. FATHER'S NAME <i>Mathias Andersen</i>	14. MOTHER'S MAIDEN NAME <i>unk</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT <i>Henry C Foss</i>	Address <i>107 Hesketh St, Cherry Chase</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>444x</i>						
DUE TO <i>ARTERIOSCLEROTIC HEART DISEASE</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ESSENTIAL HYPERTENSION</i>						
DUE TO (c) <i>GENERALIZED ARTERIOSCLEROSIS</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>SENILITY</i>						
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>June 19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5206 Norway Dr</i>	20f. (City or town) <i>Cherry Chase</i>	(County) <i>Montgomery</i>	(State) <i>Maryland</i>
21. I certify that (I) (this hospital) attended the deceased from <i>JUNE 1, 1966</i> to <i>JUNE 10, 1966</i> , that (I) (we) last saw the deceased alive on <i>JUNE 10, 1966</i> , and that death occurred at <i>3: P.M.</i> from causes and on the date stated above						
22a. SIGNATURE <i>Henry M. Lowden</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>JUNE 10, 1966</i>		
22c. PHYSICIAN'S NAME (Type) <i>HENRY M. LOWDEN</i>		22d. ADDRESS <i>5206 Norway Dr</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>6-11-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>El Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Bethesda Rd, Md</i>	(County) <i>Montgomery</i>	(State) <i>Maryland</i>
24. FUNERAL DIRECTOR <i>John E. Batts</i>		ADDRESS <i>5101 Wisconsin Ave NW</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
20 M 1/66			DATE <i>JUN 17 1966</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

38616

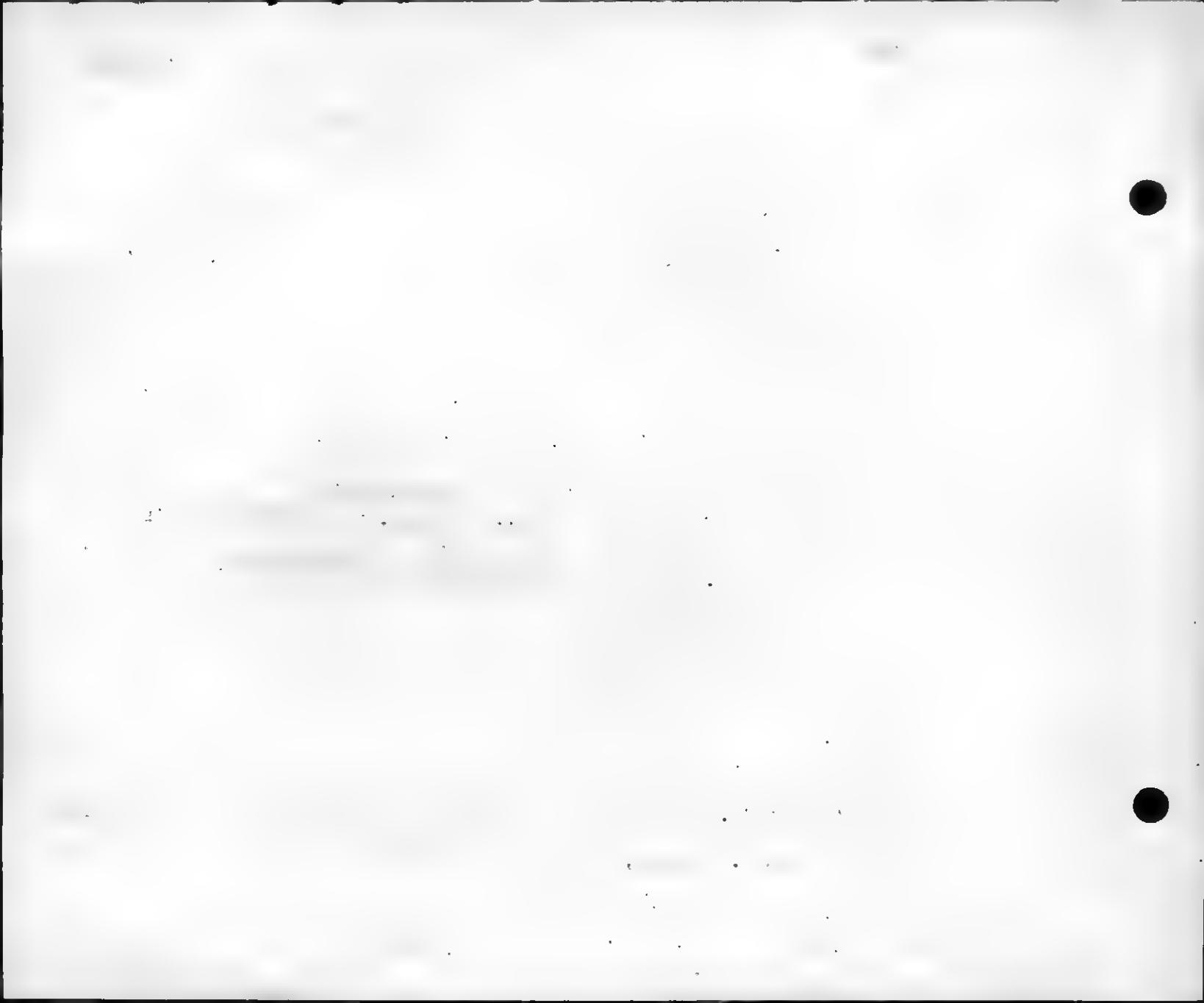
## CERTIFICATE OF DEATH

08606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 6600 Luzon Avenue, N.W., Apt. 106	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cynthia	Middle Ann	Last Foster
4. DATE OF DEATH June 15 1966	Month Day Year		
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 June 1942
9. AGE (In years last birthday) 24 yrs.	10. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James M. Savoy	14. MOTHER'S MAIDEN NAME Mary L. Newman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 577-56-0301	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertkalemia (Hyperkalemia)</u> DUE TO <u>Renal Failure and probable sepsis</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal failure and probable sepsis</u> 6mos / 1 hour (c) <u>Systemic Lupus Erythematosus</u> 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4 June 1966, to 15 June 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 15 June 1966, and that death occurred at 9:15 M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John S. Johnson, MD</u>		22b. DATE SIGNED a. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 15 June 1966	
22c. PHYSICIAN'S NAME (Type) John S. Johnson, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Washington, D.C. (State)	
24. FUNERAL DIRECTOR John T. Stewart		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
Stewart Funeral Home-4001 Benning Rd.,		MD 17 1966	



FOR STATE  
HEALTH DEPT.

08617

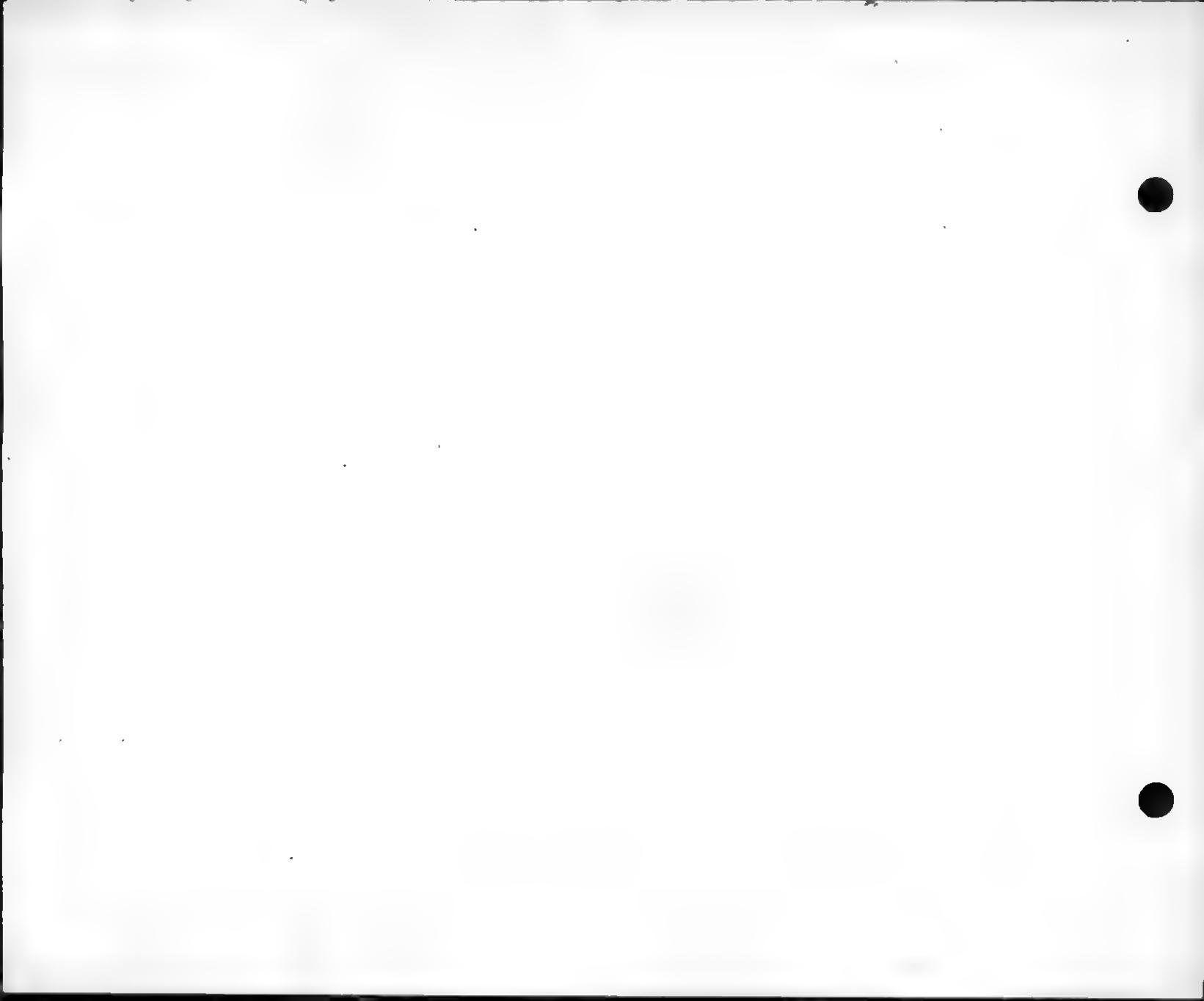
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08617

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a COUNTY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Maryland</i>		b COUNTY <i>Montgomery</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c LENGTH OF STAY IN lb <i>6 hrs - 20 min</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d STREET ADDRESS <i>116 Apple Grove Road</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Samuel</i>	Middle <i>Duane</i>	Last <i>Frederick</i>	4 DATE OF DEATH <i>June 13, 1966</i>	Month	Day	Year
5 SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <i>July 25, 1944</i>	9 AGE in years lost birthday <i>21 yrs</i>	10 UNDER 1 YEAR Months <i>0</i>	11 UNDER 24 HRS Hours <i>0</i>
10a US AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Plumbing and Heating</i>		11 BIRTHPLACE (State or foreign country) <i>Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>David H. Frederick</i>		14 MOTHER'S MAIDEN NAME <i>Blanche <del>XXXXXX</del> Greany</i>		15 INFORMANT <i>David H. Frederick</i>		Address <i>116 Apple Grove Rd. Hospital <del>XXXXXX</del>, Silver Spring, Maryland</i>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		17 SOCIA. SECURITY NO <i>None</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple traumata to neck, chest, and</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) <i>1154</i>		DUE TO (b) <i>central nervous system due to motorcycle</i>		(c) <i>accident.</i>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>June 13, 1966</i>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Deceased, driving motorcycle, ran into rear of car stopped for traffic light.</i>		20c TIME OF INJURY Month, Day, Year <i>8:20 p.m. 6/12/66</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <i>Street</i>		20f (City or town) (County) (State) <i>Hyattsville P. G. Md.</i>		20g			
21 ACTUAL SIGNATURE <i>Belden R. Peap, M.D.</i>		21c CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address <i>Hyattsville, Md.</i>		22. DATE SIGNED <i>June 13, 1966</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>June 16, 1966</i>		23c NAME OF CEMETERY OR CREMATORIUM <i>Burtonsville Union Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Burtonsville, Md.</i>	
24 FUNERAL DIRECTOR <i>John B. Thomas</i>		ADDRESS <i>8434 Georgia Avenue Tanner E. Pumphrey, Inc. Silver Spring, Md.</i>		25a RECD BY REGISTRAR <i>JUN 16 1966</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

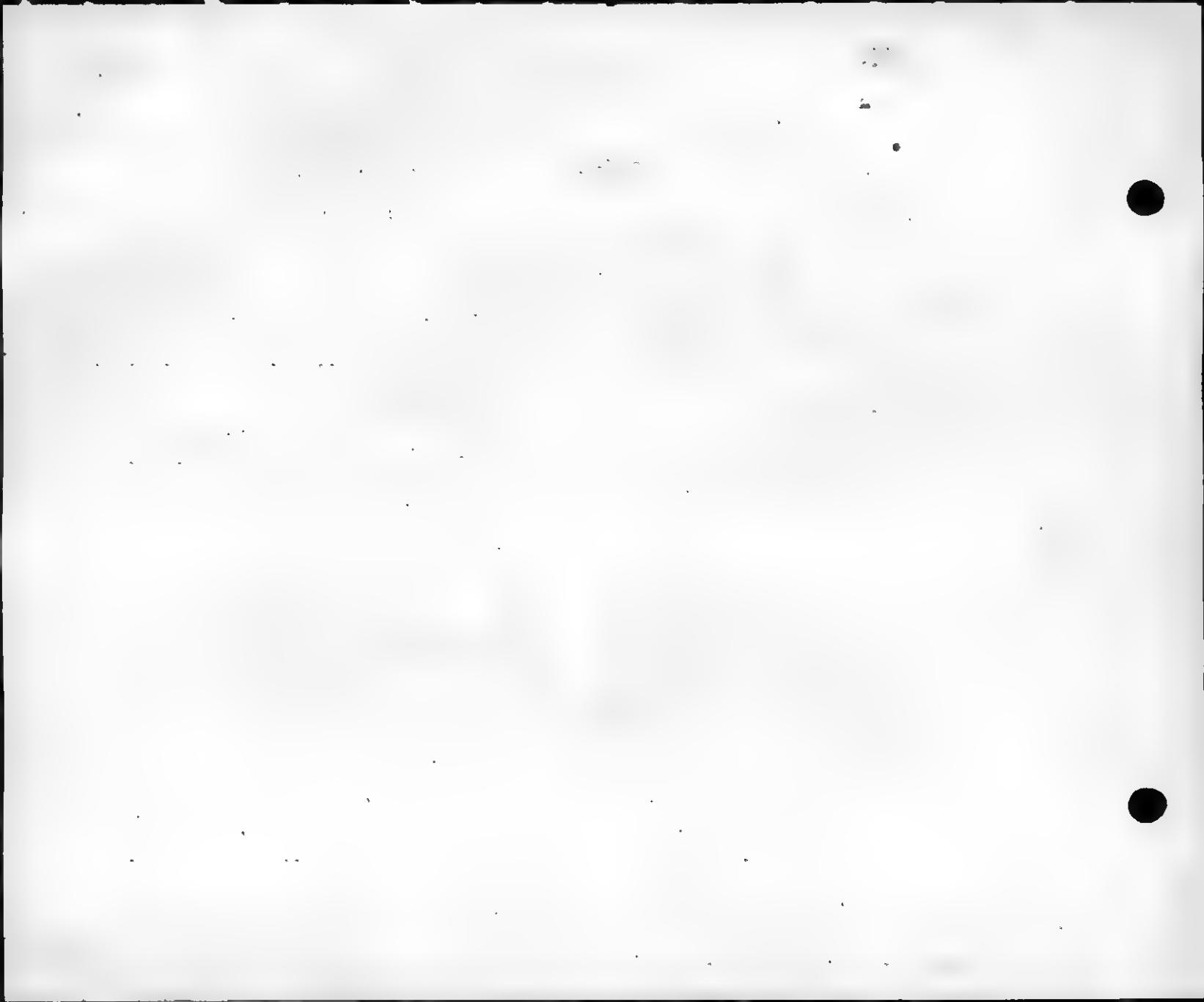
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross</i>		d. STREET ADDRESS <i>8407 Dixon Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Adah</i>	Middle <i>Willett</i>	Last <i>Freitag</i>
4. DATE OF DEATH <i>June 22 1966</i>	Month <i>June</i>	Day <i>22</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <i>July 4, 1894</i>	9. AGE (In years last birthday) <i>71 years</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery Co., Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Bradley J. Riggs</i>	14. MOTHER'S MAIDEN NAME <i>Ida Watkins</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>	
16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Ella J. Briscoe</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute Hemorrhagic PANCREATITIS</i>	Address <i>8407 Dixon Avenue Silver Spring, Md.</i>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2-3 YEARS</i>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6/20/66</i> to <i>6/22/66</i> , that (I) (we) last saw the deceased alive on <i>6/22/66</i> , and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>6/23/66</i>	
22a. SIGNATURE <i>Henry R. Wolfe</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Henry R. Wolfe</i>	22d. ADDRESS <i>905 Sheridan St., Chillum, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>June 27, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Memorial Park</i>	23d. LOCATION (City, town or county) (State) <i>Glen Burnie, Md.</i>
24. FUNERAL DIRECTOR <i>Jean Carter</i>	ADDRESS <i>8434 Georgia Avenue</i>	25a. REC'D BY REGISTRAR <i>JUN 27 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
20M 1/65			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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28619

## CERTIFICATE OF DEATH

08609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				
f. STREET ADDRESS 19 Duvall St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Carrie	Middle Eugenia	Last Fuhrman			
4. DATE OF DEATH Month June	Day 2	Year 1966				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1-16-74			
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.				
11. BIRTHPLACE (County & State, or foreign country) York, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? 				
13. FATHER'S NAME Alfred Cook		14. MOTHER'S MAIDEN NAME Emily STRICKLER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.				
17. INFORMANT Mrs. Cooke (daughter) 19 Duvall St.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5400 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 hr				
DUE TO (b) Gastric Hemorrhage		1 day				
DUE TO (c) Peptic Ulcer		1 wk.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1954, to June 3, 1966, that (I) (we) last saw the deceased alive on June 1, 1966, and that death occurred at 12 A.M., from causes and on the date stated above.						
22a. SIGNATURE Walcott W. Gibson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED June 2, 1966			
22c. PHYSICIAN'S NAME (Type) Walcott W. Gibson		22d. ADDRESS 4300 St Barnabas Road, Meadow Hts. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-4-66	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery	23d. LOCATION (City or Town) Bladensburg	(County) Maryland	(State)	
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4309 Suitland Rd Suitland Maryland	25a. REC'D BY REGISTRAR JUN 6 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		

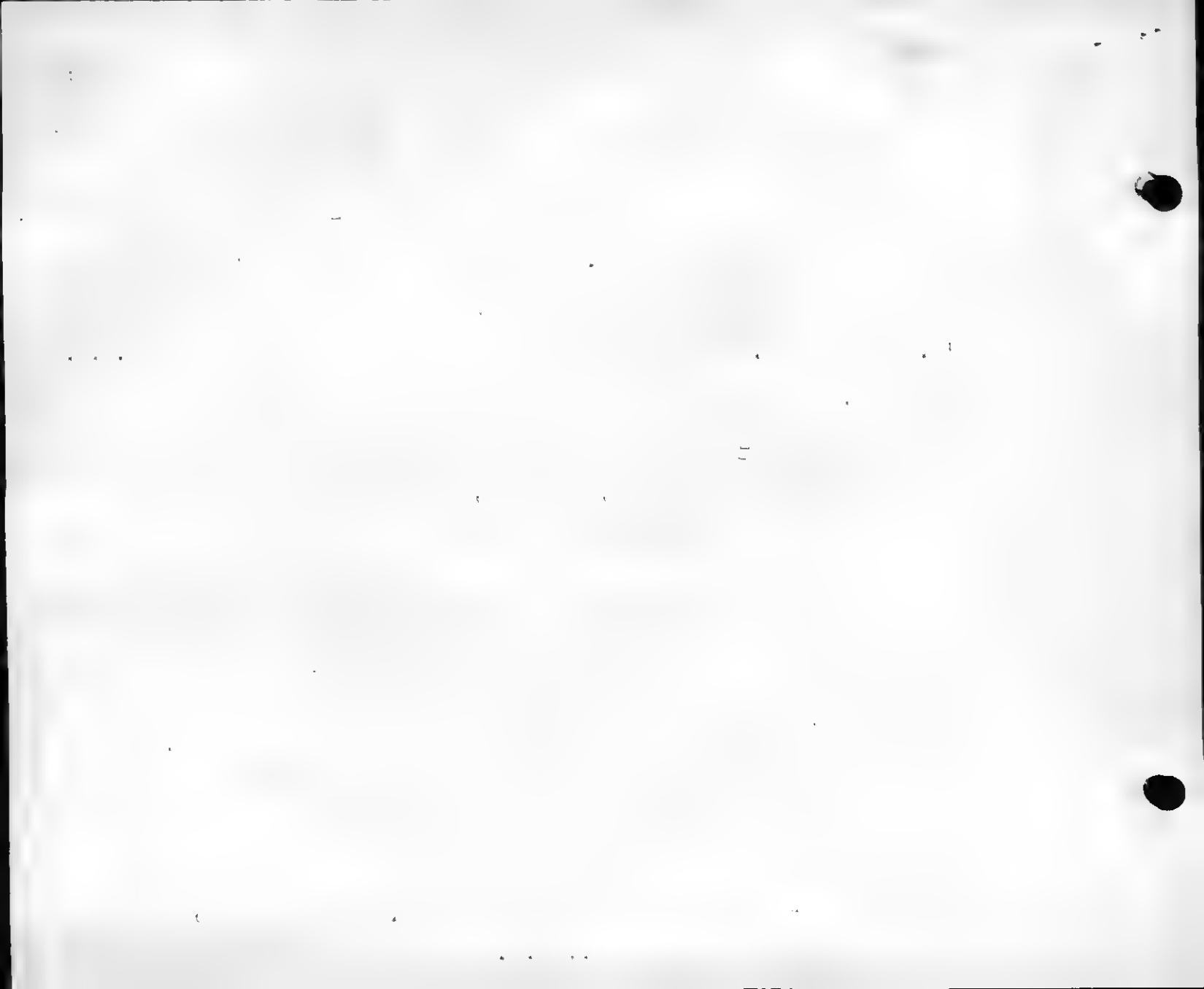


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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, above Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY			Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE			Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Bethesda			c. LENGTH OF STAY IN 1b			b. COUNTY		
5 days						Chevy Chase			Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Suburban			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year
Charles			C.	Futterer	June	16	19	66			
5. SEX			6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (last birthday)			10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	
M			W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/14/33	32	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Ass't. States Atty.			Attorney						U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Charles A. Futterer			Marianne Spellbring								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes Navy 1955-57						Dorothy Futterer			Chevy Chase 3402 Turner Lane		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
INjuries, multiple, severe											
OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Automobile Accident</u> (c)											
INTERVAL BETWEEN ONSET AND DEATH 5 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20b. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year 4:30 a.m. 6/11 1966			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) Near Rockville Mont, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)											
22. DATE SIGNED 6/16/66											
ACTUAL SIGNATURE <i>John S. Bell</i>											
EXAMINER'S NAME (Type)											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 6-18-66			23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN CEM.			23d. LOCATION (City, town or county) (State) MONTGOMERY, COUNTY		
24. FUNERAL DIRECTOR JOSEPH GAWLERS SONS			ADDRESS WASH., D.C.			25a. REC'D BY REGISTRAR JUN 22 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15ME 3500 4-64						DATE					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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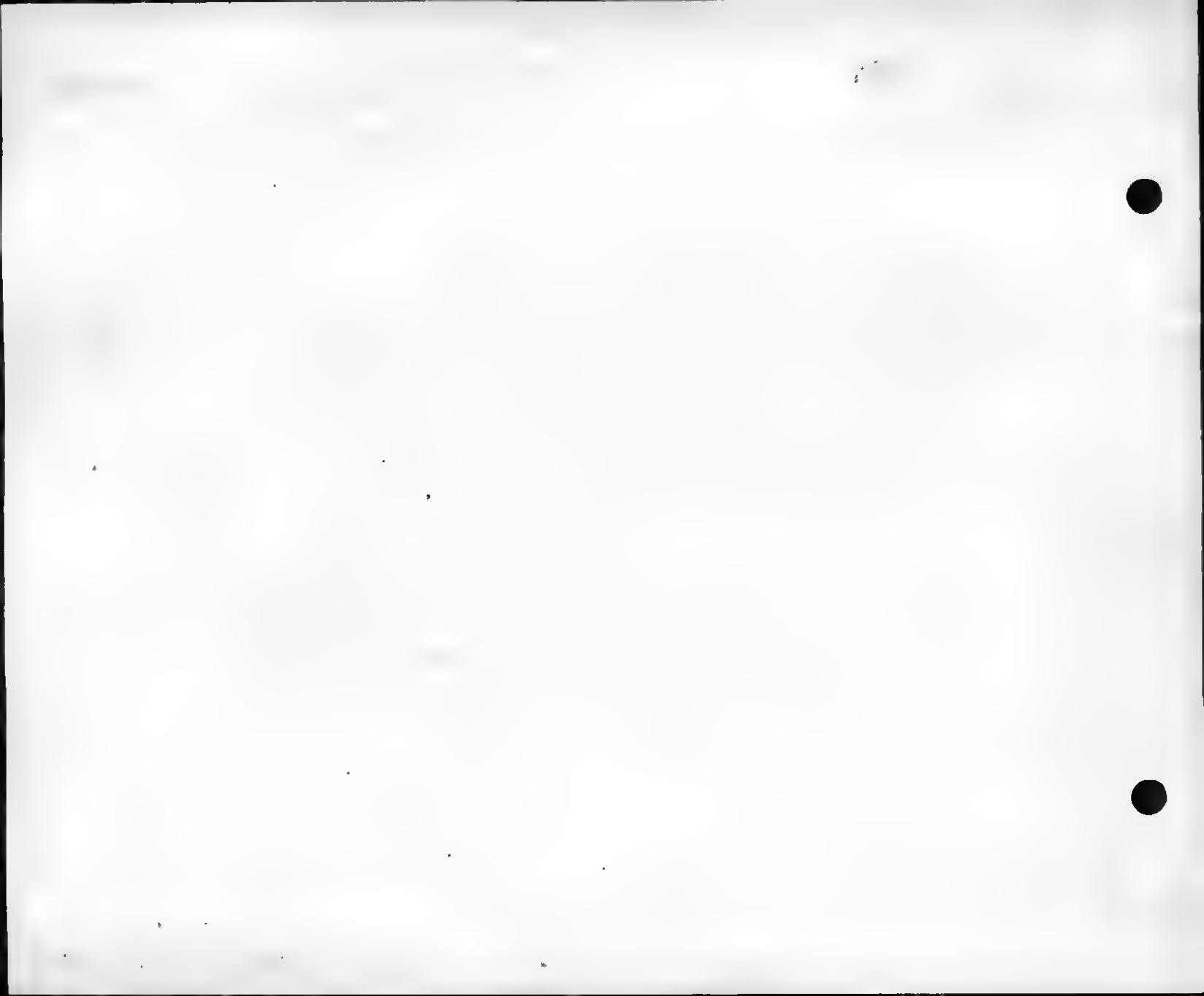
38621

## CERTIFICATE OF DEATH

118611

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fairland</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fairland Nursing Home</b>		d. STREET ADDRESS <b>1601 NAYLOR RD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Louise</b>	Middle <b>GANNON</b>	4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>1966</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 8, 1887</b>
9. AGE (in years lost birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS DAYS <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>JACOB SCHNEIDER</b>		14. MOTHER'S MAIDEN NAME <b>KALBACK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Charles Gannon</b>	Address <b>Laurel, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>10</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>lost</b> (b) DUE TO Diseases, if any, which gave rise to cause (b), stating the underlying cause <b>lost</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>April 20, 1966</b> to <b>June 6, 1966</b> that (1) (we) last saw the deceased alive on <b>June 6, 1966</b> , and that death occurred at <b>845 1/2 Ft</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A.F. Thibadeau</b>		22b. DATE SIGNED <b>6/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.F. THIBADEAU</b>	22d. ADDRESS <b>SILVER SPRING, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6 9 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>McCarthy Funeral Home</b>	ADDRESS <b>130 E. Fort Ave</b>	25a. REC'D BY REGISTRAR <b>JUN 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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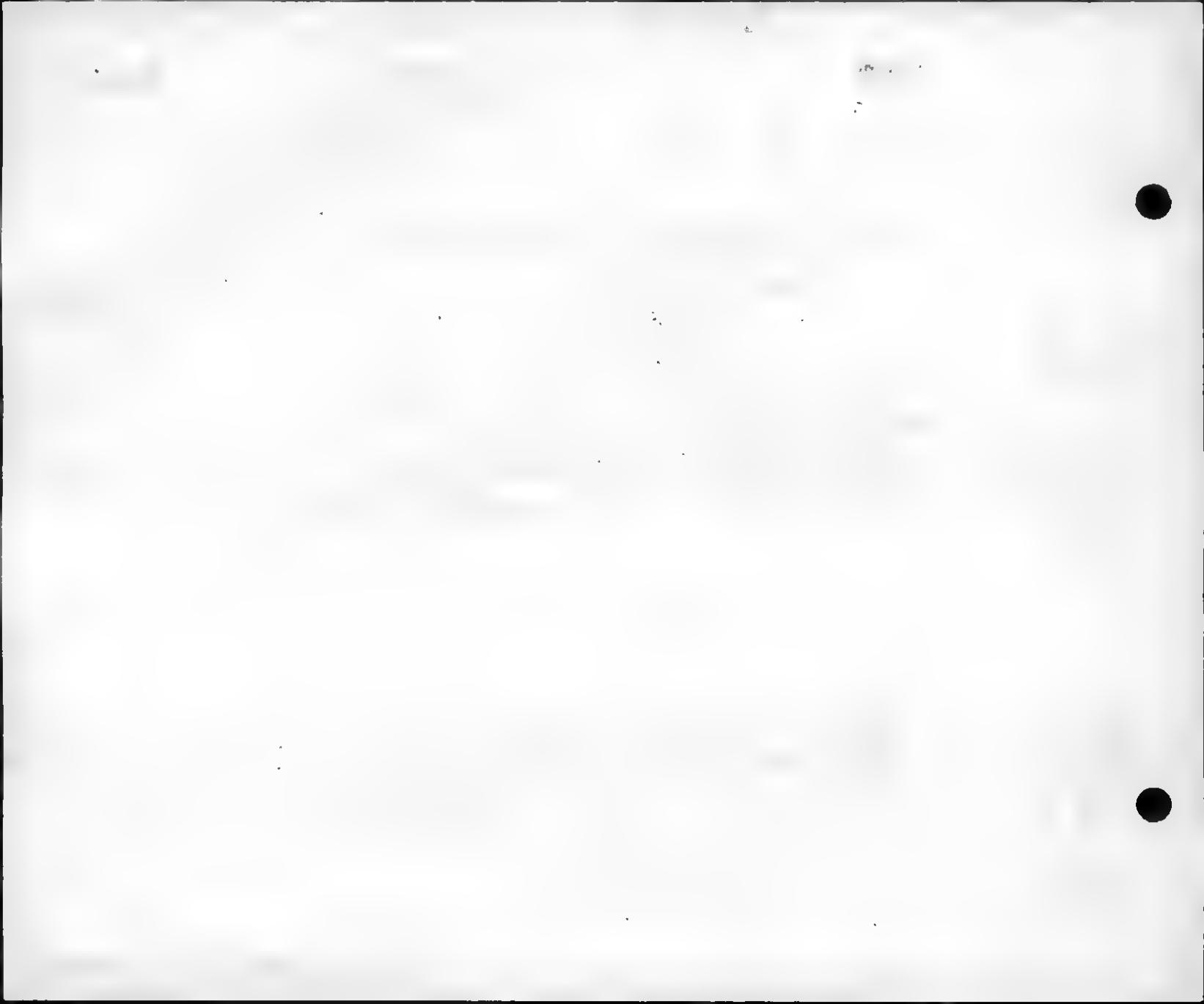
## CERTIFICATE OF DEATH

08612

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>925 Ray Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Angelina</i>		First <i>(Nina)</i>	Middle <i>Giannini</i>
4. DATE OF DEATH Month <i>6</i>	Month <i>19</i>	Day <i>19</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>7-29-93</i>	9. AGE (In years last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>	12. CITIZEN OF WHAT COUNTRY? <i>American</i>
13. FATHER'S NAME <i>Pasquale Bisacci</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Records Washington Sanitarium &amp; Hospital</i>	Address <i>Records Washington Sanitarium &amp; Hospital</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1019 Union Blvd, East S.S.</i>
20f. (City or town) <i>Hyattsville</i>		(County) (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>May 1966</i> to <i>June 19, 1966</i> that (I) (we) last saw the deceased alive on <i>June 18, 1966</i> , and that death occurred at <i>1 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Boris Patkin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Boris Patkin M.D.</i>		22d. ADDRESS <i>1019 Union Blvd, East S.S.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>6/23/1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL Cemetery</i>
23d. LOCATION (City or Town) <i>Takoma Park, Md.</i>		(County) (State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS, Inc. Silver Spring, Md.</i>		ADDRESS <i>W.W. CHAMBERS, Inc. Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>JUN 21 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL, RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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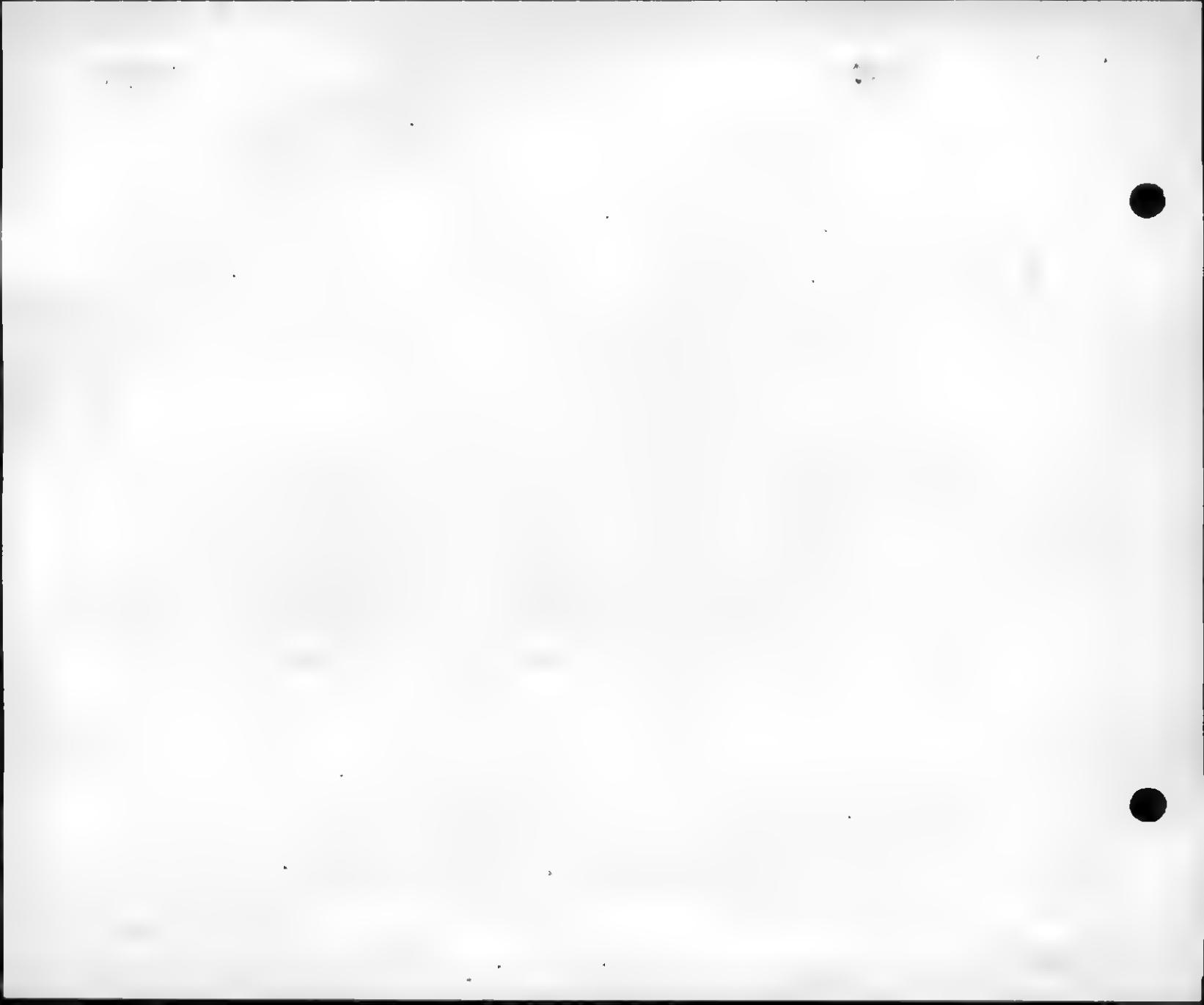
## CERTIFICATE OF DEATH

05613

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>		c. LENGTH OF STAY IN TB <i>1 Month</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Fairland Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Spencerville</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Henry</i>		First <i>C</i>	Middle <i></i>	Last <i>Gibson</i>	4. DATE OF DEATH <i>June 28 1966</i>	Month <i>June</i>	Day <i>28</i>	Year <i>1966</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>1882</i>	9. AGE in years (at birthday) <i>84 yrs</i>	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS Days <i>25</i>	12. Hours <i></i>	13. Minutes <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>William Gibson</i>			14. MOTHER'S MAIDEN NAME <i>Annie Pierce</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT		Address <i>Mary P. Gibson - wife</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Arterio-sclerotic Heart Disease.									INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Burtonsville</i>		(County) <i>Maryland</i>		(State) <i>MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>5-28 1966</i> to <i>6-28 1966</i> , that (I) (we) last saw the deceased alive on <i>6-28 1966</i> , and that death occurred at <i>2:45 AM</i> , from causes and on the date stated above.									22b. DATE SIGNED <i>6-28-66</i>		
22a. SIGNATURE <i>Burton A. Johnson, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS <i>Burtonsville Medical Bldg.</i>			
22c. PHYSICIAN'S NAME (Type) <i>Burton A. Johnson, M.D.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burtonsville</i>		23b. DATE THEREOF <i>6/30/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Union Cemetery</i>		23d. LOCATION (City or Town) <i>Burtonsville, Md.</i>		(County) <i>Maryland</i>		(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>		25. ADDRESS <i>Rockville, Md.</i>		25. REC'D. BY REGISTRAR <i>JUN 29 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

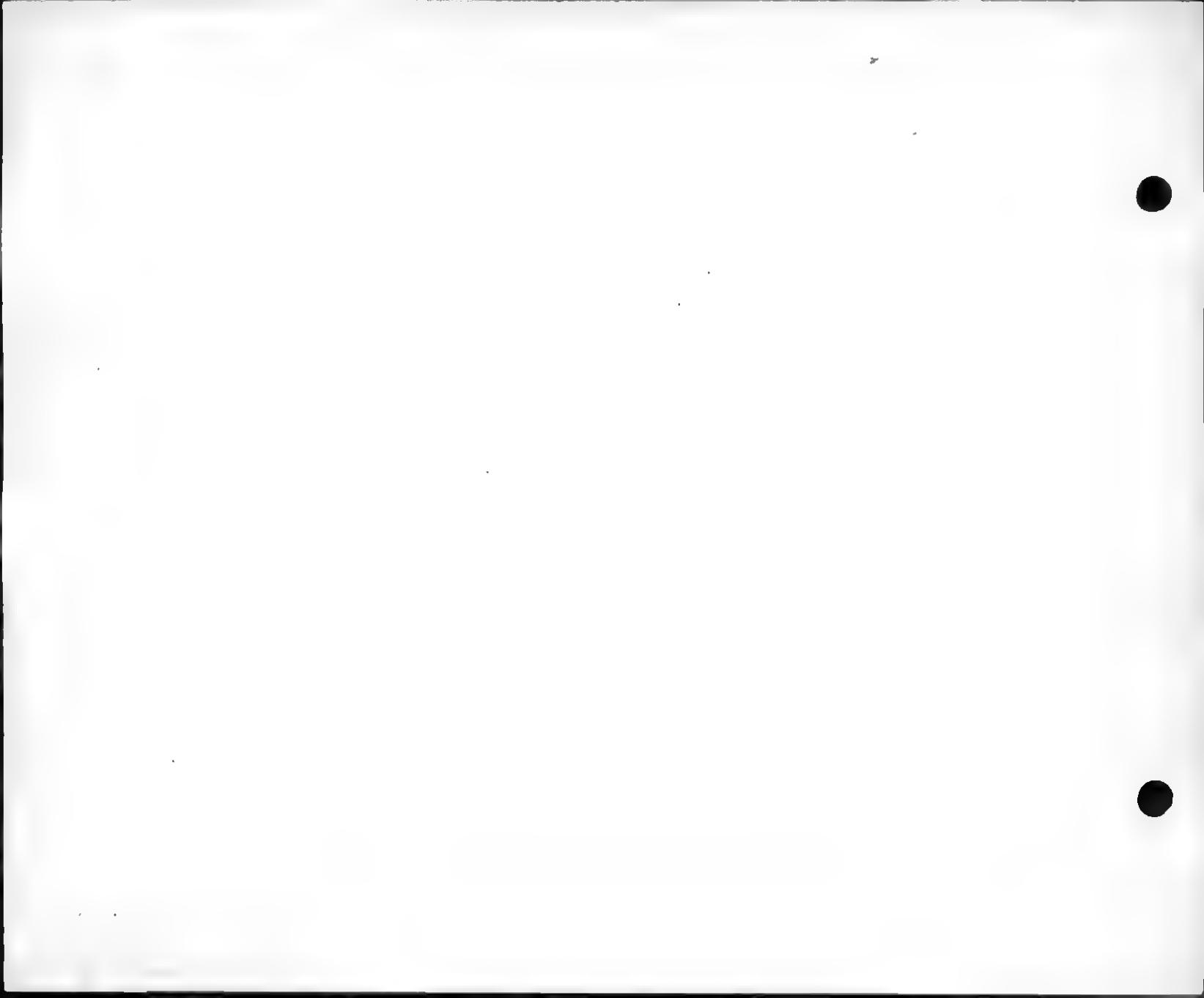
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

08624

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08614

1 PLACE OF DEATH a COUNTY <i>Montgomery</i> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Maryland</i> b COUNTY <i>Prince George's</i>	
c LENGTH OF STAY IN lb <i>8 days</i>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Landover</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium 9th Hospital</i>		d STREET ADDRESS <i>9901 Central Ave</i>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Frank</i>	Middle <i>John</i>	4 DATE OF DEATH 6 21 1966
5 SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>1-18-16</i>
9 AGE (In years last birthday) <i>49 yrs</i>	10a SOCIAL SECURITY NO <i>217-16-3424</i>	11 BIRTHPLACE (State or foreign country) <i>Italy</i>	12 CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13 FATHER'S NAME <i>Fortunato Goffe</i>	14 MOTHER'S MAIDEN NAME <i>Maria Bernikie</i>	Address	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	16 SOCIAL SECURITY NO <i>217-16-3424</i>	17 INFORMANT <i>Hospital Records</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4/12</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) <i>DUE TO</i> (c) <i>pneumonectomy.</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of Item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>9</i> p.m.	20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)	20f (City or town) (County) <i>(State)</i>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Peap, M.D.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> I.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Washington</i>		
22. DATE SIGNED <i>6/21/1966</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE THEREOF <i>6-24-66</i>	23c NAME OF CEMETERY OR CREMATORIALY <i>Mt Olivet Cemetery</i>	23d LOCATION (City or Town) (County) <i>(State)</i> <i>Washington D. C.</i>
24 FUNERAL DIRECTOR <i>W. Neim Funeral Home</i>	ADDRESS <i>4301 Suitland Rd Suitland Maryland</i>	25a RECEIVED BY REGISTRAR DATE <i>JUN 27 1966</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08625

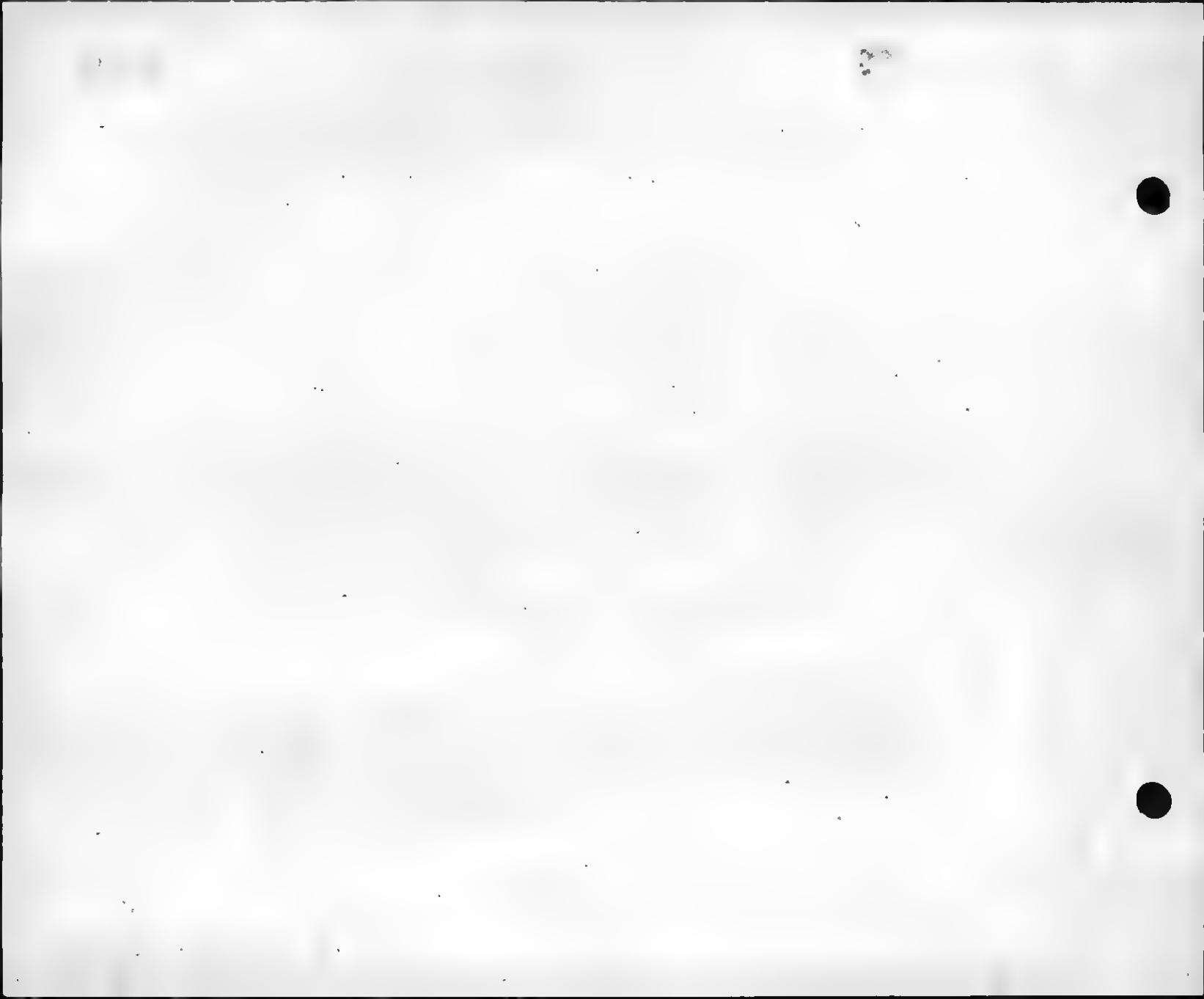
## CERTIFICATE OF DEATH

08615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>23 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>KENSINGTON GARDENS SANATORIUM</i>		d. STREET ADDRESS <i>6201 Bradley Blvd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>John Day</i>		First	Middle	Last	4. DATE OF DEATH <i>June 24 1966</i>	Month	Day	Year	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 9 1877</i>	9. AGE (in years lost birthday) <i>89 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>Printing</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Taylor Green</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Walters Day</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>See J. Green</i>		17. INFORMANT <i>Address: Bradley Blvd, Bethesda Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i>		DUE TO <i>arteriosclerosis &amp; v. disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>arteriosclerosis</i>		DUE TO <i>generalized arteriosclerosis</i>		5 yrs					
				20 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>June 24 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>House</i>		20f. (City or town) (County) (State) <i>Washington, D.C.</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>June 6, 1965, to June 24, 1966</i> that (I) (we) last saw the deceased alive on <i>June 24, 1966</i> and that death occurred at <i>7 A.M.</i> from causes and on the date stated above.									
22a. SIGNATURE <i>John Day</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/24/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>18 E Kreuzburg</i>		22d. ADDRESS <i>7652 16th NW Washington, D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>6/27/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>		23d. LOCATION (City, or Town) (County) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR <i>Arthur Walters Washington, D.C.</i>		ADDRESS <i>254 Carroll St. N.W.</i>		25a. RECD. BY REGISTRAR <i>SUN 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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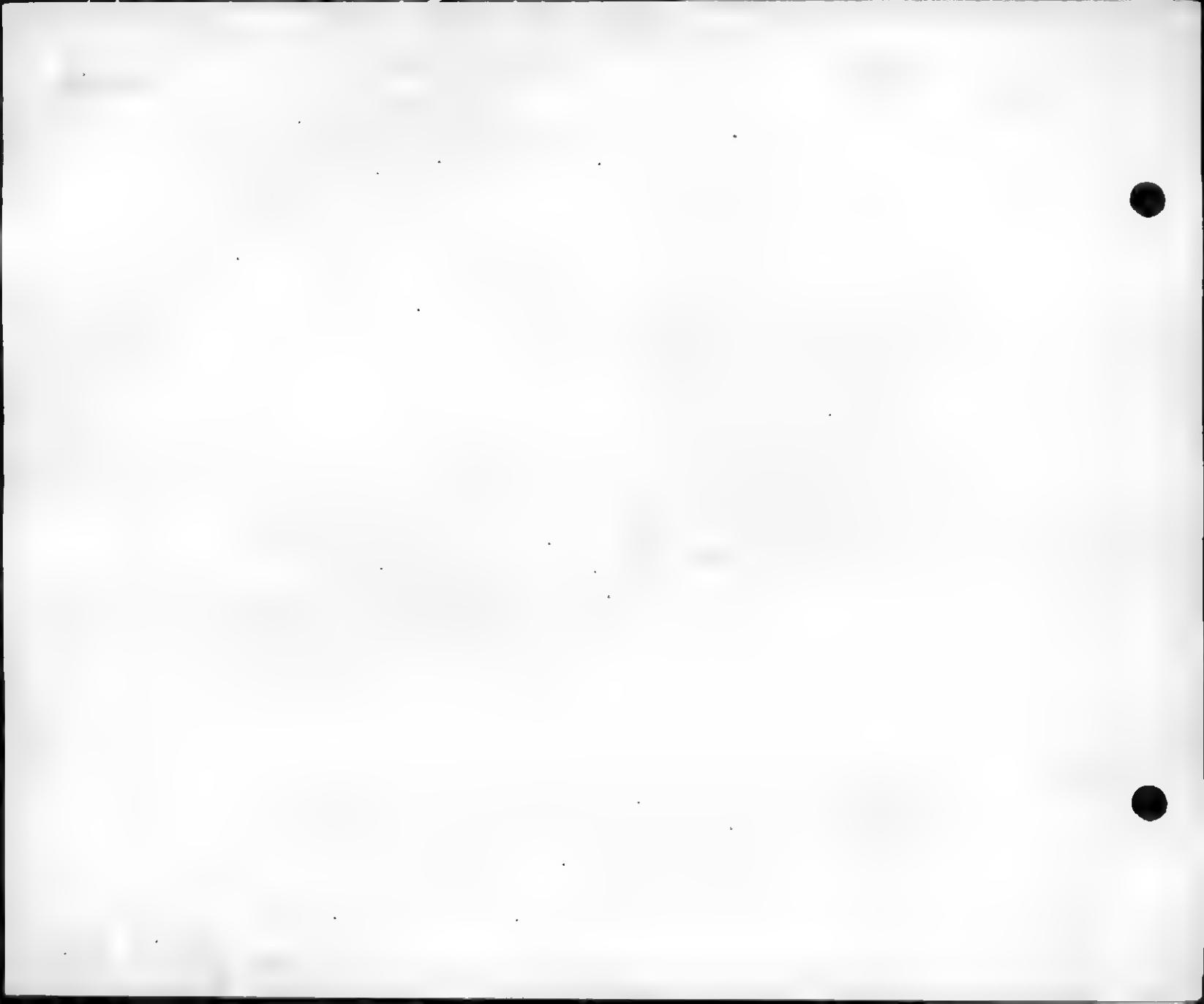
## CERTIFICATE OF DEATH

08616

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <b>2108 BELVEDERE Blvd</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SYLVAN MANOR HEALTH CARE CENTER</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>LAWRENCE</b>	Middle	Last <b>GREENSPAN</b>	4. DATE OF DEATH Month <b>JUNE</b> Day <b>25</b> Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/95</b>		9. AGE (In years last birthday) <b>70 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Solderman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOES</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, md</b>	
13. FATHER'S NAME <b>RAFUEL GREENSPAN</b>		14. MOTHER'S MAIDEN NAME <b>FRIEDA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>U.S. W. I.</b>		16. SOCIAL SECURITY NO. <b>579-44-650</b>		17. INFORMANT <b>Aaron Gardino</b> <b>1712 Tilton Dr</b> <b>SILVER SPRING, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1930</b> DUE TO <b>Hyperperphie</b> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <b>Benzylpho Phenoxazone</b> (c) <b>Glioblastoma Multiforme - Brain</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>MD</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>June 2</b> , 1966, to <b>June 25</b> , 1966, that (I) (we) last saw the deceased alive on <b>June 25</b> , 1966, and that death occurred at <b>1120 1/2 W</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Robert J. Thibadeau</b> M.D.			22b. DATE SIGNED <b>6-26-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Robert J. THIBADEAU</b>			22d. ADDRESS <b>KOKEVILLE, MD 20852</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-26-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>RENTON HILL CEM.</b>	
23d. LOCATION (City or Town) <b>Capitol Heights</b> (County) <b>Maryland</b> (State) <b>MD</b>					
24. FUNERAL DIRECTOR <b>Charles J. Judge</b>		ADDRESS <b>1217 Grand St. NW</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

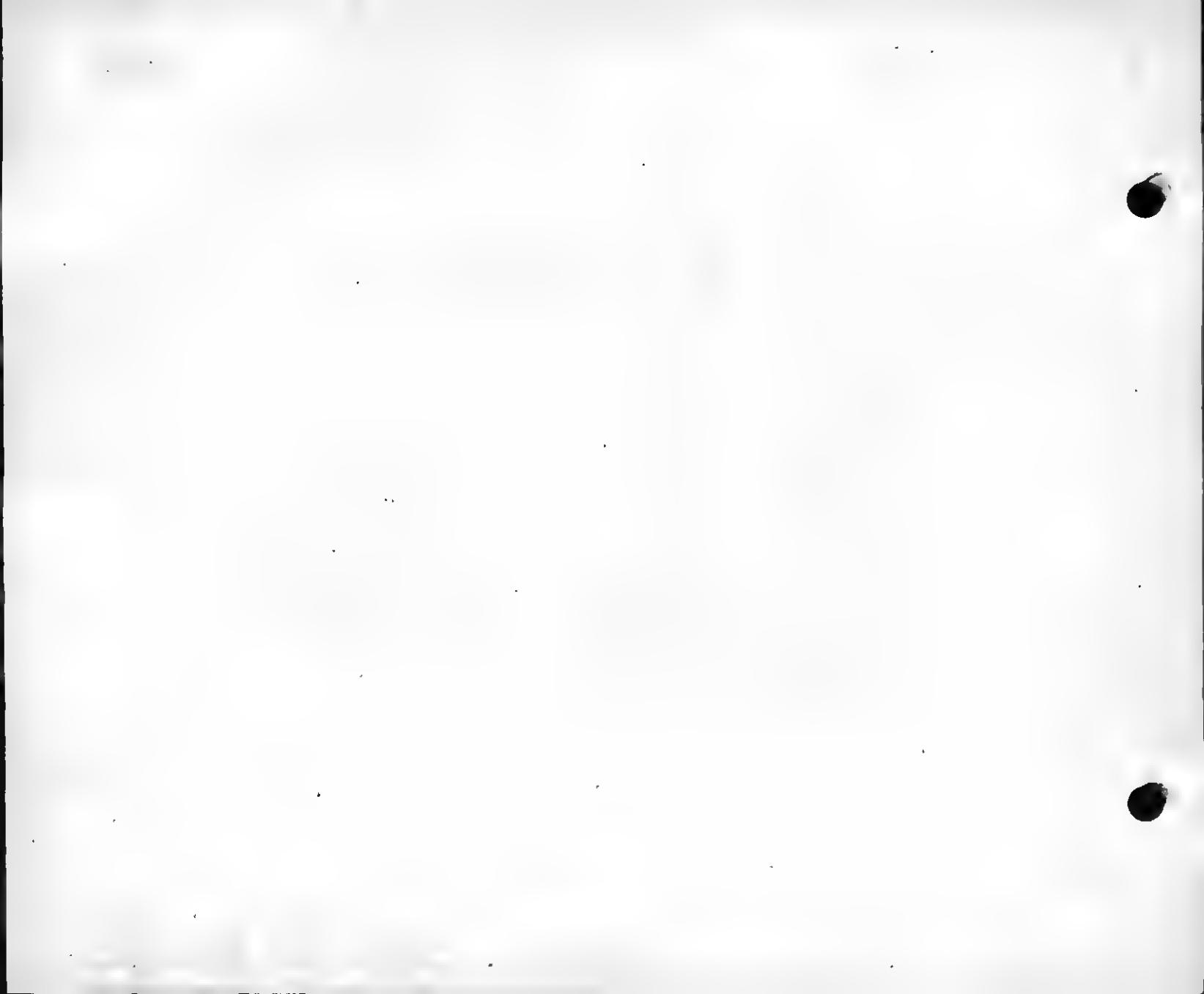
08627

08617

Dr. Ball, Coroner has released the body of W. H. Thomas to the funeral director, page 3 should be detached for use as the burial-transit permit. The Death Certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal.

M

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<u>MONTGOMERY</u>		<u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<u>SILVER SPRING</u>		<u>MARYLAND</u>	
c. LENGTH OF STAY IN 1B 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>12914 Georgia Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HELEN</u>		First	Middle
4. DATE OF DEATH <u>June 1 1966</u>		Last	Month
5. SEX <u>F</u>		Day	Year
6. COLOR OR RACE <u>CAU</u>		8. DATE OF BIRTH <u>8/13/1908</u>	9. AGE (in years last birthday) <u>96</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank E. Klopher</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Blanchard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-0492</u>	
17. INFORMANT <u>Paul Gregorio</u>		Address <u>12914 Georgia Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Thrombosis</u>			
DUE TO (b) <u>Ruptured Myocardium</u>			
DUE TO (c) <u>Acute Myocardial infarction</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
<u>June 1 1966</u>		<u>While at work</u>	<u>Baltimore</u>
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 1966, to <u>June 1</u> , 1966, that (I) (we) last saw the deceased alive on <u>June 1</u> , 1966, and that death occurred at <u>7:50</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Ira N. Tublin</u>			
22b. DATE SIGNED <u>June 6</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ira N. Tublin</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS <u>800 Pershing Dr., S. S., Md.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 6, 1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cemetery</u>
23d. LOCATION (City, town or county) <u>Silver Spring, Maryland</u>		(State)	
24. FUNERAL DIRECTOR <u>Frank Thomas</u>		ADDRESS <u>8434 Georgia Avenue</u>	25a. REC'D BY REGISTRAR <u>JUN 8 1966</u>
Warner E. Pumphrey, Inc.		Silver Spring, Md.	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

M

08628

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

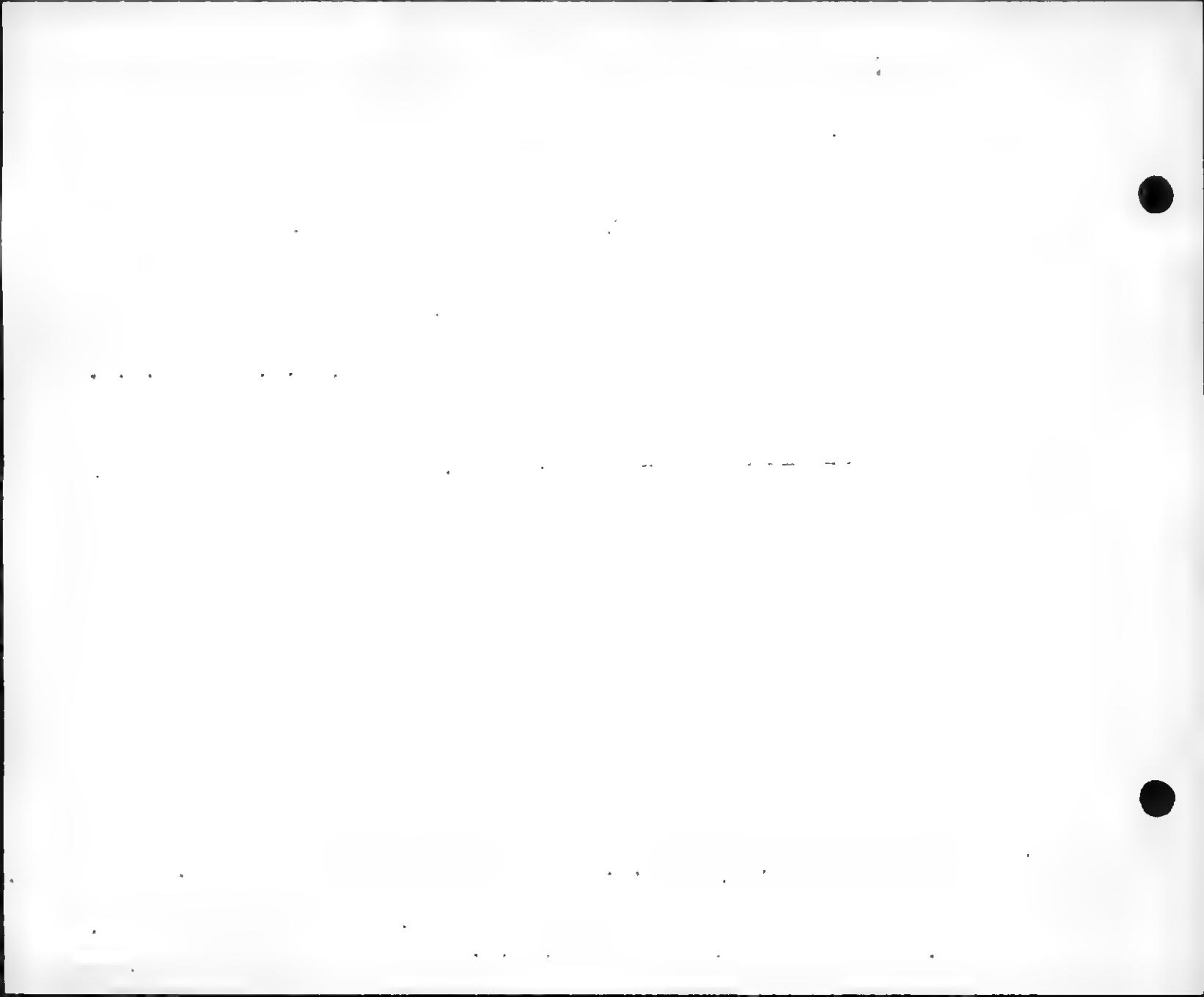
08618

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda.</b>		c. LENGTH OF STAY IN lb <b>DOA.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		e. STREET ADDRESS <b>7504 Brookville Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Rheesa.</b>		4. DATE OF DEATH <b>June - 3 1966.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Fe.</b>	6. COLOR DR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>3/30-1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9. AGE (In years last birthday) <b>82 yrs</b>	
10b. KIND OF BUSINESS DR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Eugene Albert Ridgway</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213-46-8758</b>	
17. INFORMANT <b>John A. Griesbauer, Same as item #2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) <b>Cardio Vascular Disease.</b> DUE TO stating the underlying cause lost (b) <b>Cardio Vascular Disease.</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Montgomery</b> (County) <b>Montgomery</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>John G. Ball, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Montgomery County, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/6/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cem.</b>
23d. LOCATION (City or Town) <b>Silver Spring</b> (County) <b>Md.</b>		23e. REG'D BY REGISTRAR <b>JUN 8 1966</b>	
24. FUNERAL DIRECTOR <b>Jos. Gawler's Sons, Washington, D.C.</b>		25a. ADDRESS <b>1111 18th St. N.W. Washington, D.C.</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

C 11-21-66

08623

## CERTIFICATE OF DEATH

08619

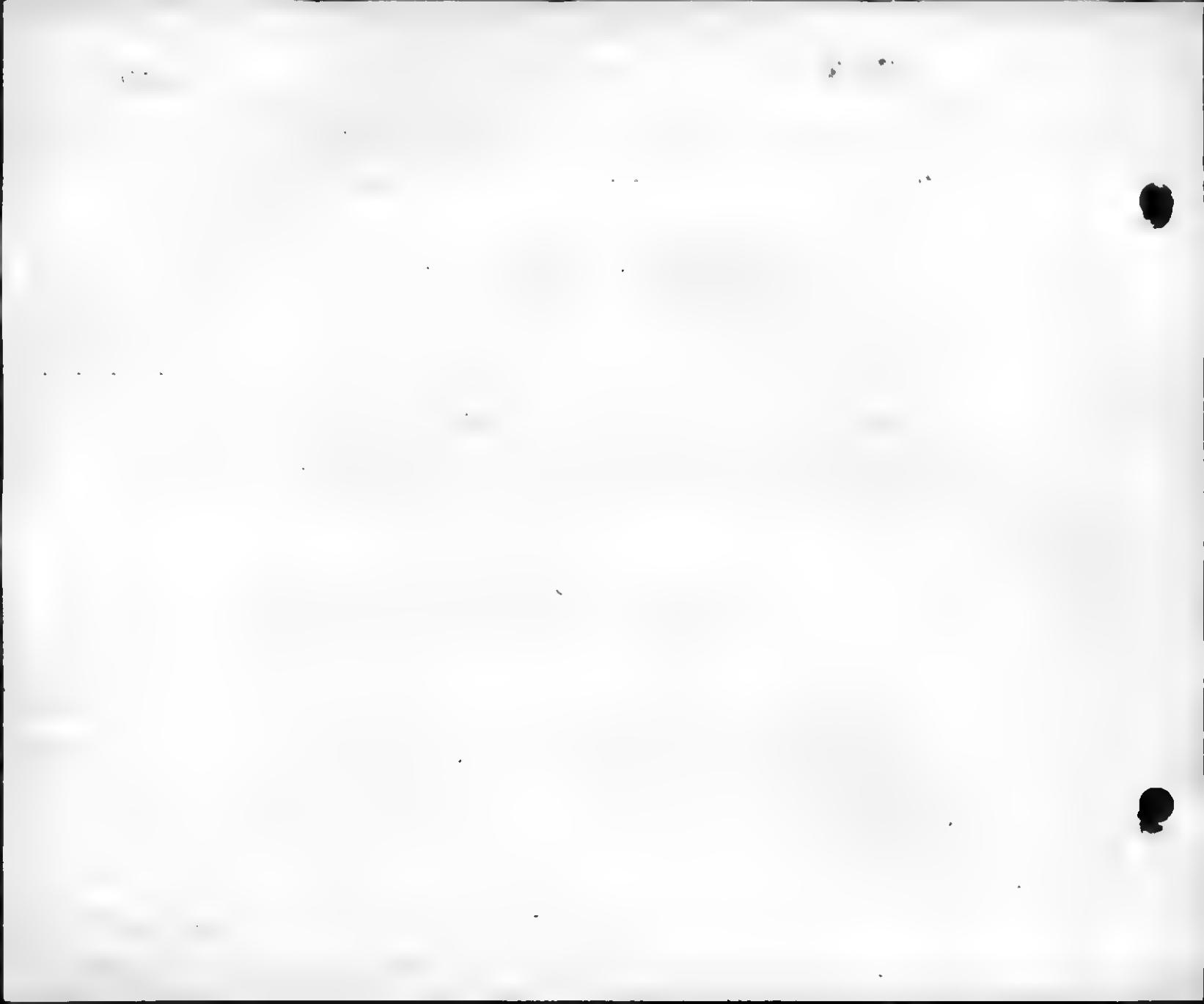
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charles W. Vossler - Medical Examiner - State Bureau of Vital Statistics M.D.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>W. Hyattsville</i>	
c. LENGTH OF STAY IN TB D.O.A?		c. STREET ADDRESS <i>1407 Merrimac Dr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street, address) <i>Wash. Surg. &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Elizabeth</i>	4. DATE OF DEATH Month <i>6</i> Day <i>5</i> Year <i>1966</i>
S. SEX <i>F.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sep. 12, 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9. AGE (In years lost birthday) 72 yrs	
10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Kansas City, Kansas</i>	
13. FATHER'S NAME <i>John Daniel O'Keefe</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO. <i>577-03-9471</i>	
17. INFORMANT <i>James V. Griffis</i>		18. ADDRESS <i>407 Merrimac Drive W. Hyattsville, Md.</i>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Irreversible Coronary Thrombosis. a</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>acute congestive heart failure.</i>			
4-101 (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>degenerative heart disease.</i>			
4-101 (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>degenerative heart disease.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>N/A.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>N/A</i> p.m. <i>N/A</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>
20f. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-5-66</i> , to <i>6-5-66</i> , 19, that (I) (we) last saw the deceased alive on <i>6-5-66</i> , 19, and that death occurred at <i>WASH. M.</i> from causes and on the date stated above.			
22. SIGNATURE <i>James W. Vossler M.D.</i>		22b. DATE SIGNED <i>6-5-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>James W. Vossler M.D. D.P.M.</i>		22d. ADDRESS <i>10620 Ga. Ave. Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 8, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>Elton Carter</i>		25a. ADDRESS <i>8434 Georgia Avenue</i>	
24. FUNERAL DIRECTOR <i>Warren E. Humphrey, Inc.</i>		25b. REC'D BY REGISTRAR <i>JUN 10 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Part 1, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

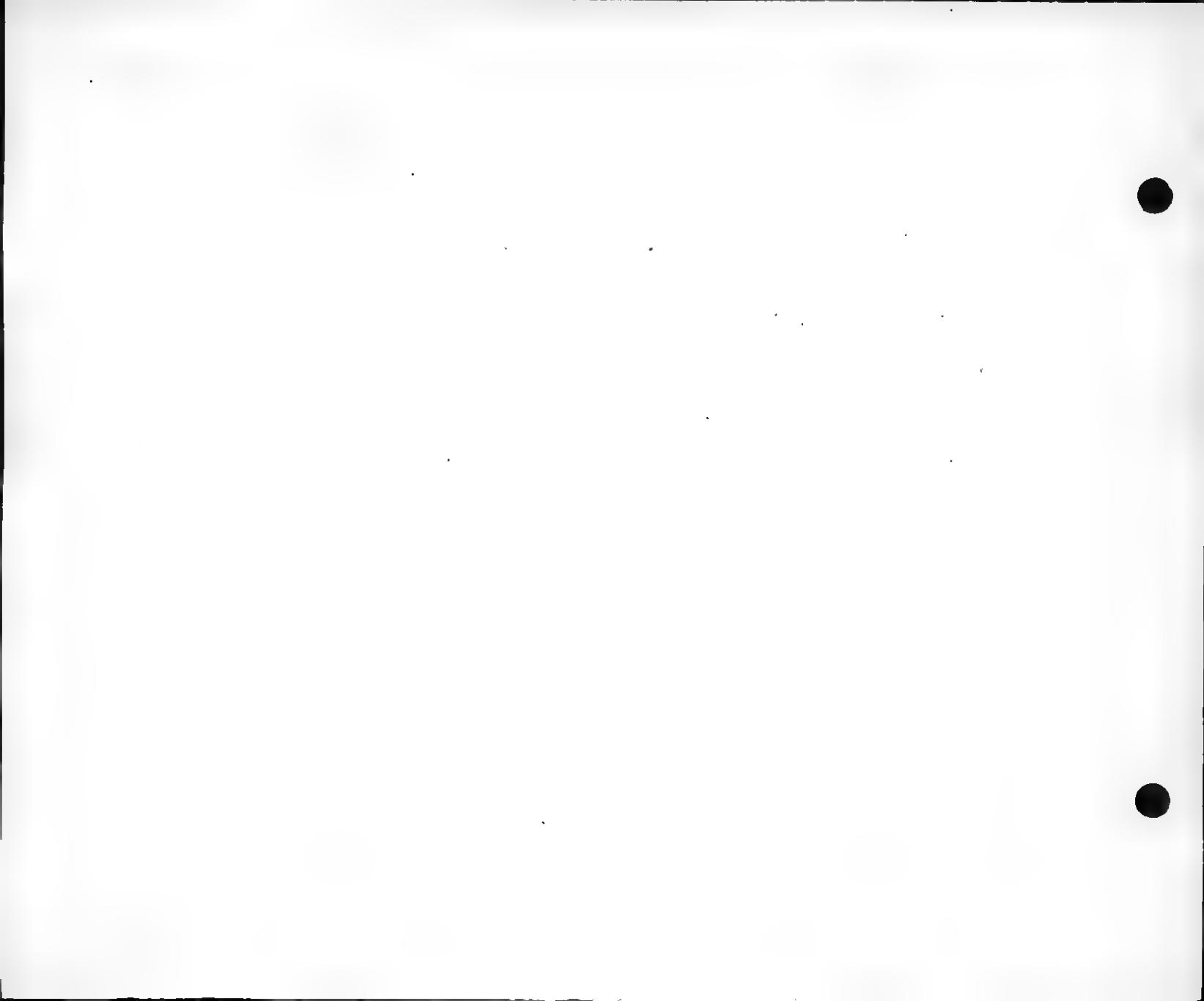
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08630

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08620

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Catharine Christel Grubb</b>	First	Middle	Last
4 DATE OF DEATH <b>June 27, 1966</b>	Month	Day	Year
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3-18-85</b>
9 AGE (In years last birthday) <b>81 yrs</b>	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS DAYS	12 HOURS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b KIND OF BUSINESS OR INDUSTRY	13 BIRTHPLACE (State or foreign country) <b>Md.</b>	
14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15 FATHER'S NAME <b>William Chiswell</b>	
16 SOCIAL SECURITY NO		17 INFORMANT <b>Hospital Records</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Complete thrombotic occlusion, basilar artery</b>  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>artery; Generalized arteriosclerosis,</b> stating the underlying cause (c) <b>marked.</b>		19 INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Belden R. Yeap M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. YEAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>6/27/1966</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL/CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>6/29/66</b>	
23c NAME OF CEMETERY OR CREMATORIAL <b>Monocacy</b>		23d LOCATION (City or Town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>Md.</b>	
24 FUNERAL DIRECTOR <b>Constance C. Hilton Barnesville, Md.</b>		25a ADDRESS <b>Constance C. Hilton Barnesville, Md.</b>	
25b REC'D BY REG STRR <b>Charles Judge</b>		25c REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY Montgomery MARYLAND		a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 30 minutes c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 3 Pooks Hill Rd., Apt. 313 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Preston Bennett HAINES		First Middle Last	4. DATE OF DEATH June 1 19 66
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Navy - Retired	
13. FATHER'S NAME Lemuel Haines		14. MOTHER'S MAIDEN NAME Isabelle Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1909-1946		16. SOCIAL SECURITY NO 578-48-5349A	
17. INFORMANT Mrs. Marion B. Haines, 3 Pooks Hill Rd./		Address Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with old myocardial infarction		10 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) Generalized Arteriosclerosis	
DUE TO (c)		approx. 20- 25 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 19 66, to June 1, 19 66, that (we) last saw the deceased alive on June 1, 19 66, and that death occurred at 305PM, from causes and on the date stated above.		22b. DATE SIGNED 2 June 1966	
22c. PHYSICIAN'S NAME (Type) Howard Rubenstein, M.D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-6-66	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D. BY REGISTRAR DATE JUN 6 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

Coroner notified &amp; will approve.

08633

## CERTIFICATE OF DEATH

08622

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda	DOA	Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Duke Hospital		4515 Gladys Driv	
3. NAME OF DECEASED (Type or print)		First	Middle
George W. Harp		First	Middle
4. DATE OF DEATH	Month	Day	Year
June 25	1966		
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED
Male	W	<input checked="" type="checkbox"/>	<input type="checkbox"/>
WIDOWED	DIVORCED	8. DATE OF BIRTH	
		3/20/1915	51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State or foreign country)	
IBM Operator		Southern R. R.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Henry Harp		Ruth M. Haffey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
Yes		718-10-6022	
17. INFORMANT		Address	
Mrs. Ruth Smith (Mother)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		1 year	
DUE TO Malnutrition			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		1 year	
DUE TO Cancer of Tongue			
lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 27, 1966, to June 28, 1966, that (I) (we) last saw the deceased alive on June 28, 1966, and that death occurred at 112 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph P. Kenner		MD ATTENDING PHYS.	22b. DATE SIGNED 6/28/66
22c. PHYSICIAN'S NAME (Type) Dr. JOSEPH P. KENNER		22d. ADDRESS 6450 Wisconsin Ave, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-1-66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl Cem.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS	25a. LOCATION (City or Town) (County) (State) Arlington, Virginia
			25b. REC'D BY REGISTRAR DATE JUL 1 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08633

## CERTIFICATE OF DEATH

08623

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE							
Montgomery Maryland		Washington D.C.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Takoma Park		c. LENGTH OF STAY IN 1b 4 Days 10 hrs							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San + Hosp		e. STREET ADDRESS 1321 Fern Street N.W.							
3. NAME OF DECEASED (Type or print)		First Earl	Middle Groshong Harrington						
4. DATE OF DEATH		Month June	Day 10						
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
Male		White	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	10-27-89	76 yrs				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Government worker		11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lewis Harrington			14. MOTHER'S MAIDEN NAME Mary Groshong		15. INFORMANT Lillian Harrington - wife				
16. SOCIAL SECURITY NO. No			17. INFORMANT 579-60-3713		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			DUE TO (b) Cerebral Ane.		INTERVAL BETWEEN ONSET AND DEATH 1st in 1962. 1963				
(c) Cerebral Ane. Popl. heart.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Debilities			Last 4 1/2 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Last 4 1/2 yrs.						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg, etc)	20f. (City or town) 6/10/66	(County) Baltimore	(State) Md		
21. I certify that (I) (this hospital) attended the deceased from 6/10/66 to 6/10/66, that (I) (we) last saw the deceased alive on 6/10/66, and that death occurred at 38 M, from causes and on the date stated above.					22b. DATE SIGNED 6/10/66				
22a. SIGNATURE Howard T Morse			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) Howard T Morse			22d. ADDRESS 130 Carroll Ave Takoma Park Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b. DATE THEREOF 6-13-66	23c. NAME OF CEMETERY OR CREMATORIAL FT LINCOLN CREMATORIAL WASH	23d. LOCATION (City or Town) D.C.	(County) D.C.	(State) Md		
24. FUNERAL DIRECTOR JOSEPH CAULERS, Son, Esq., Washington			ADDRESS		25a. RECD BY REGISTRAR JUN 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge			

100

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

18624

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>DSA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>		d. STREET ADDRESS <b>718 S. STONESTREET Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Rita</b>	Middle <b>Elvia</b>	Last <b>HARRINGTON</b>	4. DATE OF DEATH <b>JUNE 24 1966</b>	Month Day Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>2/4/96</b>	9. AGE (In years at birthday) <b>70 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woodward &amp;洛夫</b>		11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>BERNARD HONNEMAN</b>		14. MOTHER'S MÄDEN NAME <b>Sophia BERRY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Rita MAGEE - DAUGHTER - SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4330</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Heart Block		INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Rockville</b>	(County) (State) <b>Maryland</b>
21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>6/24 1966</b> that (I) (we) last saw the deceased alive on <b>6/21 1966</b> , and that death occurred at <b>4330</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Frank G. Jagger, Jr.</b>		M.D. ATTENDING PHYS.	22b. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <b>6/24/66</b>
22c. PHYSICIAN'S NAME (Type) <b>FRANK G. JAGGERS JR.</b>		22d. ADDRESS <b>5707 WISCONSIN AVE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 27, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Rockville Cemetery</b>	23d. LOCATION (City or Town) <b>Rockville</b>	(County) (State) <b>Maryland</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	25a. REC'D BY REGISTRAR DATE <b>JUN 29 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

2000

1 M  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08635

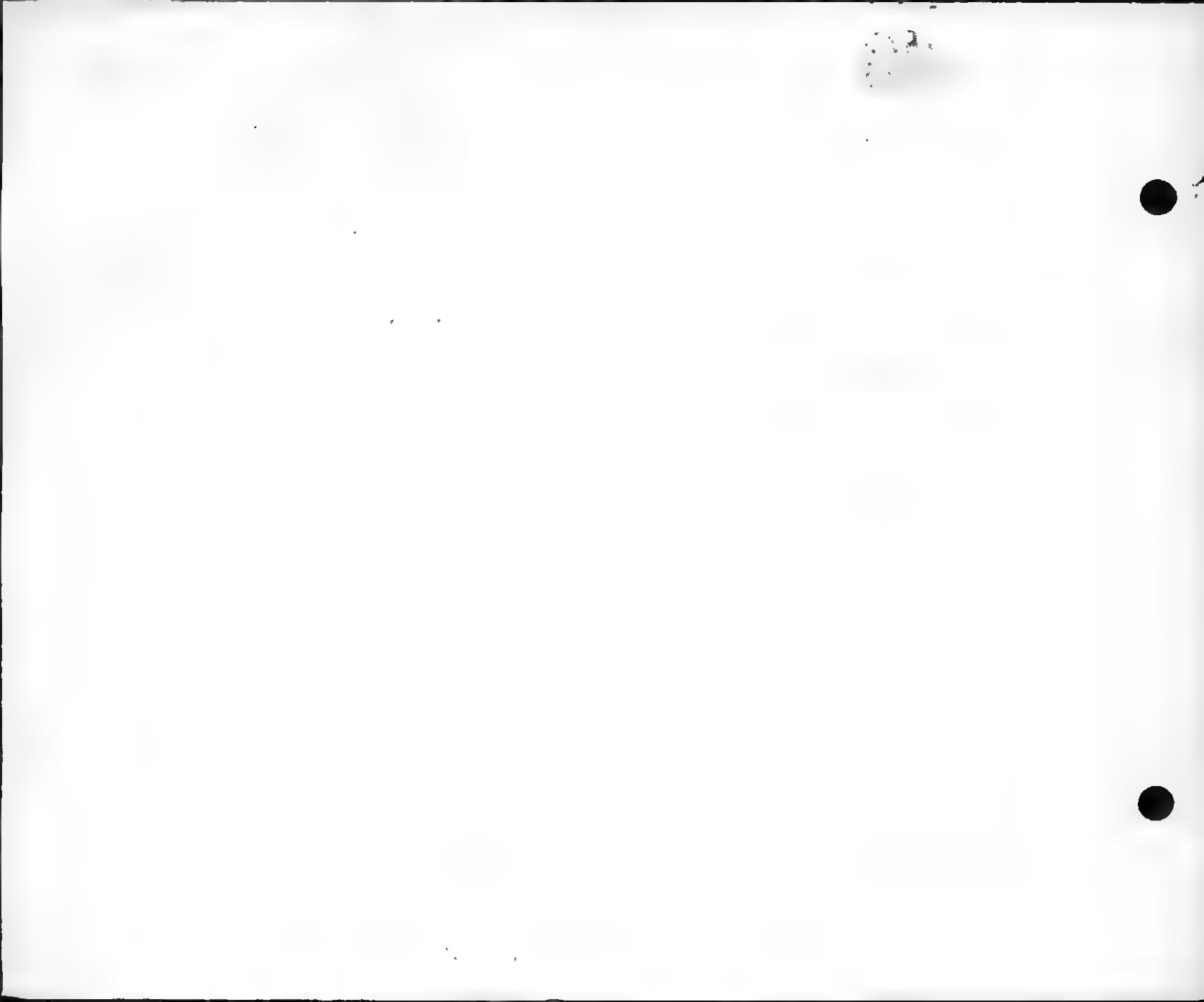
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08625

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, in any event within 72 hours after death.

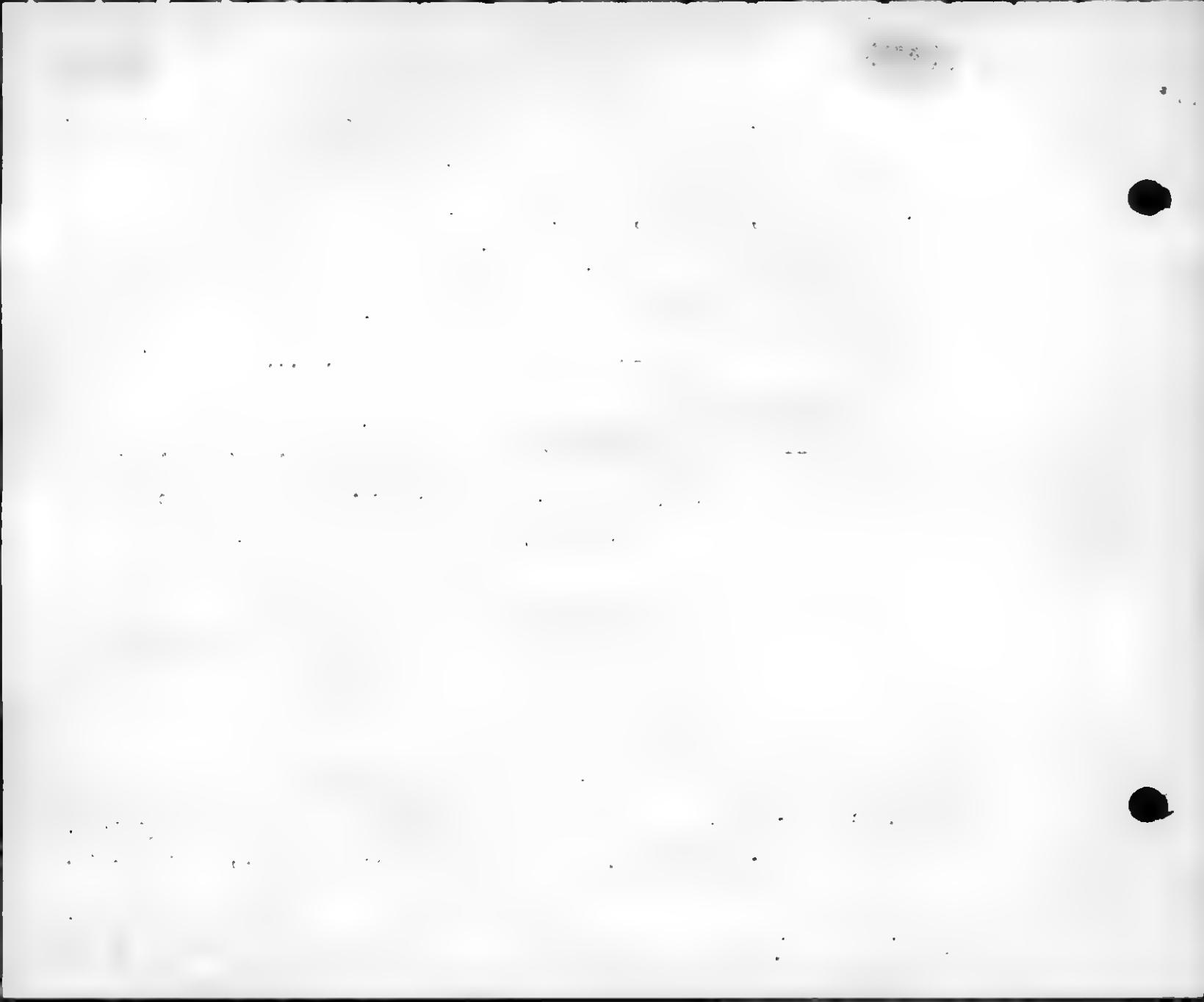
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		b. COUNTY <b>WASHINGTON</b>			
c. LENGTH OF STAY IN lb <b>DoA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CHILLIAM PLACE</b>		d. STREET ADDRESS <b>904 NEW YORK AVE</b>			
3. NAME OF DECEASED (Type or print) <b>JIMMIE</b>		First <b>HART</b>	Middle 4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>1966</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED WIDOWED NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>		
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Will Hart</b>		14. MOTHER'S MAIDEN NAME <b>Ellie Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>1160 000 0000</b>			
17. INFORMANT <b>Brother Jessie Wash. D.C.</b>		18. CAUSE OF DEATH (Enter on one line per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5811</b> DUE TO <b>Fatty. Metamorphos. of Liver Acute.</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Pounding. Chronic. Alcoholism.</b> DUE TO (c)			
19. INTERVAL BETWEEN DEATH AND DEATH <b>30 min.</b>					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY DETERMINED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John S. Boll</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>6/25/66</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-4-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR <b>S. J. Taylor</b>		25a. ADDRESS <b>909 6th St, N.W. D.C.</b>	25b. REC'D BY REG STRR DATE <b>JUL 5 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH						08636 118626					
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Montgomery MARYLAND			Bethesda			26 Days			a. STATE Maryland b. COUNTY Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			The Clinical Center, Bethesda, Maryland			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Silver Spring		
3. NAME OF DECEASED (Type or print)			First	Middle	Stimmel	Last	4. DATE OF DEATH	Month	Day	Year	
Mildred			Elizabeth	Hart		June	10	19	66		
5. SEX			6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
Female White			WIDOWED	DIVORCED	6 December 1914	51 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife			Own home			Washington, D.C.			USA		
13. FATHER'S NAME			Robert Stimmel			14. MOTHER'S MAIDEN NAME			Bessie Mills		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			The Medical Records		
No			509-03-9244			The Clinical Center, Bethesda, Maryland			The Clinical Center, Bethesda, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			19. INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, secondary to leaking duodenal stump			26 Days								
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			(b) Rheumatoid arthritis with steroid therapy								
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 15 May, 1966, to 10 June, 1966 that <input type="checkbox"/> (we) last saw the deceased alive on 10 June 1966, and that death occurred at 10:50 PM, from the causes and on the date stated above.											
22a. SIGNATURE Kirby Orme									22b. DATE SIGNED 11 June 1966		
22c. PHYSICIAN'S NAME (Type)			Kirby Orme, MD.			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF June 13, 1966			23c. NAME OF CEMETERY OR CREMATORIAL Port Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Prince Georges Md.		
24. FUNERAL DIRECTOR John Thomas Warner E. Pumphrey, Inc.			ADDRESS 8434 Georgia Avenue Silver Spring, Md.			25a. REC'D BY REGISTRAR JUN 14 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8637

## CERTIFICATE OF DEATH

08627

HOSPITAL  ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rockville

c. LENGTH OF STAY IN IB

?

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

103 Forest Avenue

3. NAME OF DECEASED  
(Type or print)

First

Middle

Estelle

R.

HARTLEY

Last

4. DATE  
OF  
DEATH

JUNE 25

Month

Day

19 66

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

Feb. 4, 1893

9. AGE (In years  
last birthday)

73 yrs.

10. IF UNDER 1 YEAR

4

11. IF UNDER 24 HRS.

Hours

Min.

11a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

11b. KIND OF BUSINESS OR INDUSTRY

11c. BIRTHPLACE (County &amp; State, or foreign country)

11d. CITIZEN OF WHAT COUNTRY

Rockville, Maryland

USA

13. FATHER'S NAME

Wallace E. Ricketts

14. MOTHER'S MAIDEN NAME

Emma Mullican

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Unknown

Dr. Gilbert V. Hartley-Husband-Same Item #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last

(b)

POSSIBLE PRIMARY BRAIN MALIGNANCY

INTERVAL BETWEEN  
ONSET AND DEATH

3 MONTHS

DUE TO

(c)

BRONCHIOGENIC CARCINOMA

8 MONTHS

15 MONTHS

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.20d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from M.A.Y. 17, 1965, to JUNE 26, 1966, that (I) (we) last  
saw the deceased alive on JUNE 25, 1966, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Gordon S. Rosenberger, M.D.

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22b. DATE  
SIGNED

June 26, 1966

22c. PHYSICIAN'S  
NAME (Type) 22d. ADDRESS  
Gordon S. Rosenberger, M.D. 310 W. Montgomery Ave., Rockville, Md.23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial June 28, 1966 Parklawn

23d. LOCATION (City, town or county)

(State)

Rockville

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE  
Robert A. Pumphrey ADDRESS  
Bethesda, Maryland25a. REC'D BY REGISTRAR  
DATE JUN 29 1966  
25b. REGISTRAR'S SIGNATURE  
j Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

98633

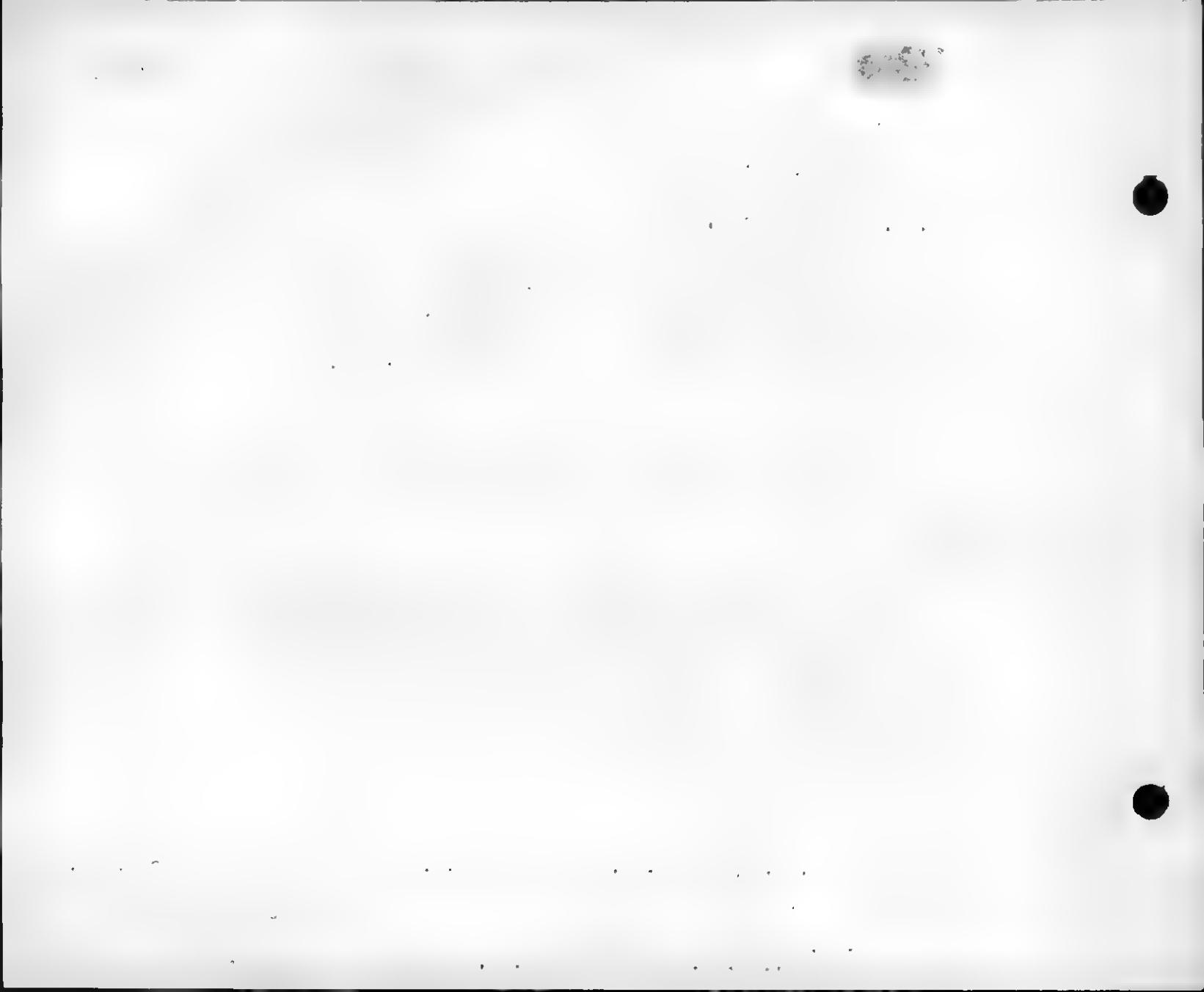
## CERTIFICATE OF DEATH

08628

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the both certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>1701 East West Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Andrew Holt HARTTER</b>		First <b>Andrew</b>	Middle <b>Holt</b>	Last <b>HARTTER</b>	4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 66</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1966</b>	9. AGE (In years last birthday) yrs <b>22</b> Months <b>22</b> Days <b>10</b> Hours <b>10</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Bethesda, Md.</b>	
13. FATHER'S NAME <b>Donald Hartter</b>		14. MOTHER'S MAIDEN NAME <b>Susan Holt</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b> <b>NONE</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Captain Donald Hartter, 1701 East West Hwy</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intraventricular Hemorrhage associated with prematurity</b> DUE TO <b>7605</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>prematurity</b> DUE TO <b>lost.</b> (c)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <b>(this hospital)</b> attended the deceased from <b>May 31</b> , 19 <b>66</b> , to <b>June 1</b> , 19 <b>66</b> , that <b>(we)</b> lost saw the deceased alive on <b>June 1</b> , 19 <b>66</b> , and that death occurred at <b>455PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>J. T. Lynch</b>		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2 June 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. T. Lynch, M. D.</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/3/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 23d. LOCATION (City or Town) (County) (State) <b>El Paso, Illinois</b>	
24. FUNERAL DIRECTOR W. W. Chambers Funeral Home 1400 Chapin St., N. W. Washington, D. C.		25a. REC'D BY REGISTRAR DATE <b>JUN 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

32639

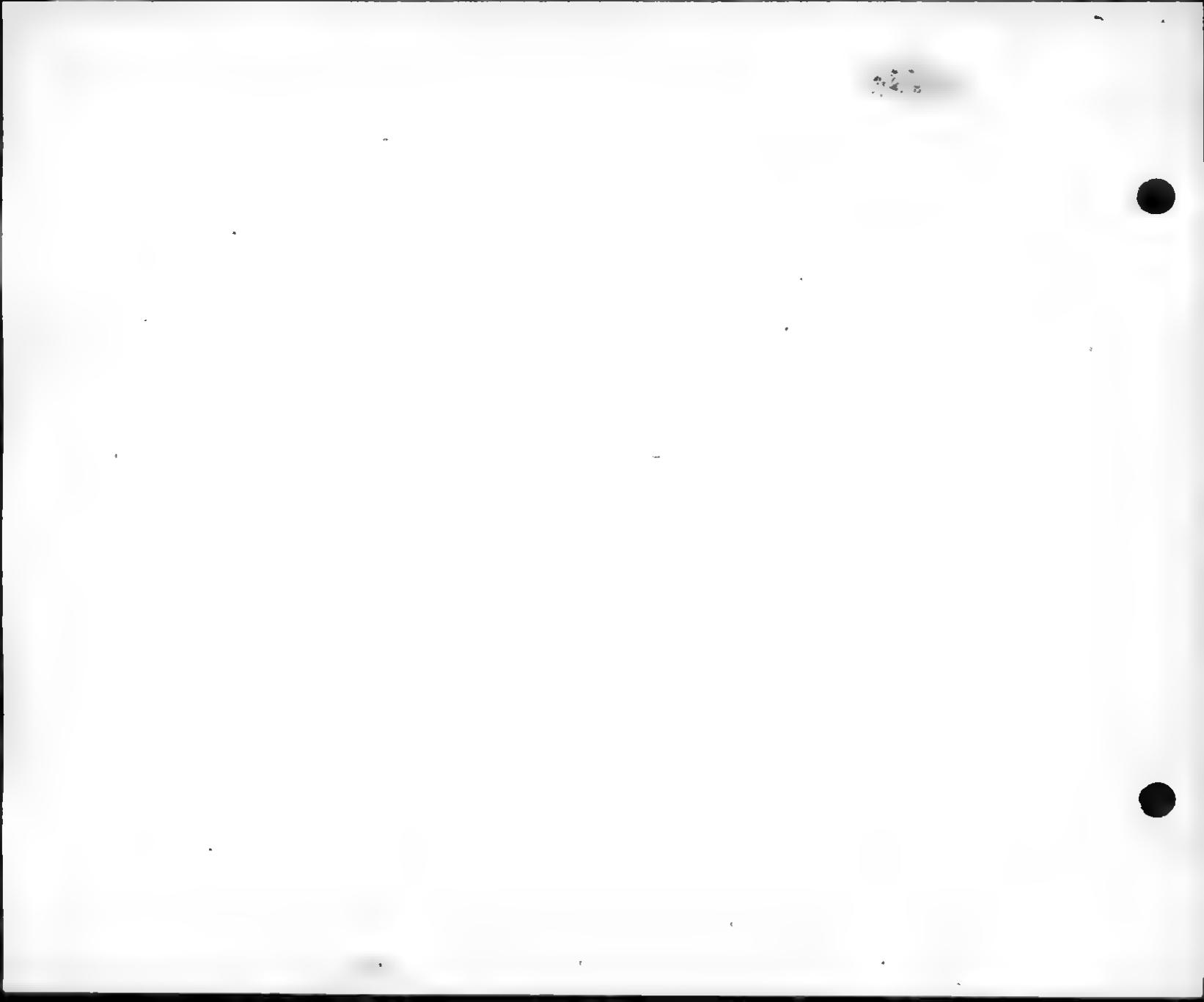
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05629

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN b. 50 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 1106 Mierscher St.	
3. NAME OF DECEASED (Type or print) Paul Douglas		4. DATE OF DEATH June 6 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-5-51
10a. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor		10b. KIND OF BUSINESS OR IND. STRY Student	9. AGE (In years last birthday) 17 yrs
11. BIRTHPLACE (State or foreign country) Chambours, I'a		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Hawbecker		14. MOTHER'S MAIDEN NAME Germaine Lambert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO 220-54-1829	17. INFORMANT Edwin Hawbecker Address 1106 Mierscher St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Acute meningococcal meningitis. INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) Arlington, Virginia	
23a. BURIAL, Cremation, Removal (Specify) Burial		23b. DATE THEREOF June 30, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National
24. FUNERAL DIRECTOR Robert A. Pumphrey		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
ADDRESS Bethesda, Maryland		25a. RECD BY REGISTRAR DATE: JUL 1 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



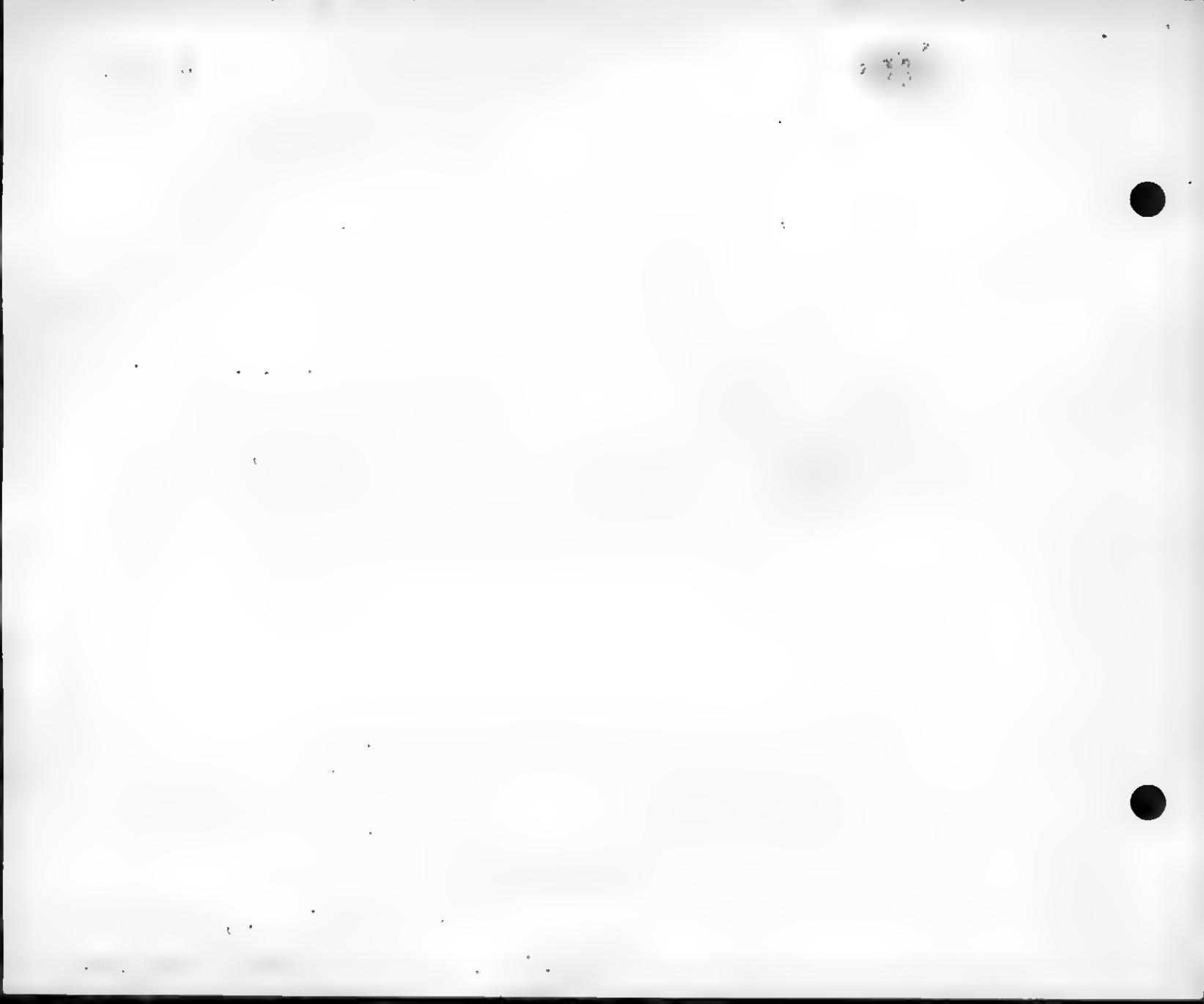
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08640 CERTIFICATE OF DEATH 08630

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>48 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>			d. STREET ADDRESS <b>4513 HARRISON ST.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Andrew J. HEARD</b>			4. DATE OF DEATH <b>JUNE 12 1966</b>	Month	Day
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/1892</b>	9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR <b>Months</b> <b>Days</b> IF UNDER 24 HRS <b>Hours</b> <b>Min</b>
10. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if not recd.) <b>Retired Printer US Government</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>US Government</b>	11. BIRTHPLACE (County & State or foreign country) <b>Washington, D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Henry Heard</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Loretta Baldwin</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Lucie Heard Raymond, item # 2</b>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENO CARCINOMA OF COLON</b> DUE TO <b>---</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>					
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause (b) <b>---</b> DUE TO <b>---</b> (c) <b>---</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>---</b>	(County) <b>---</b> (State) <b>---</b>
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 10, 1966</b> , to <b>June 12, 1966</b> , that (I) (we) last saw the deceased alive on <b>JUNE 11 1966</b> , and that death occurred at <b>9:10 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Dewitt E. Delmoter</b>		22b. DATE SIGNED <b>---</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dewitt E. Delmoter, MD</b>		22d. ADDRESS <b>80254 BERDEEN RD Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/14/1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) <b>Suitland</b>	(County) <b>Ma</b> (State) <b>---</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, 5130 Wisc. Ave. NW</b>		ADDRESS <b>Wash. DC</b>	25a. REC'D BY REGISTRAR <b>JUN 14 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Justice</b>	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

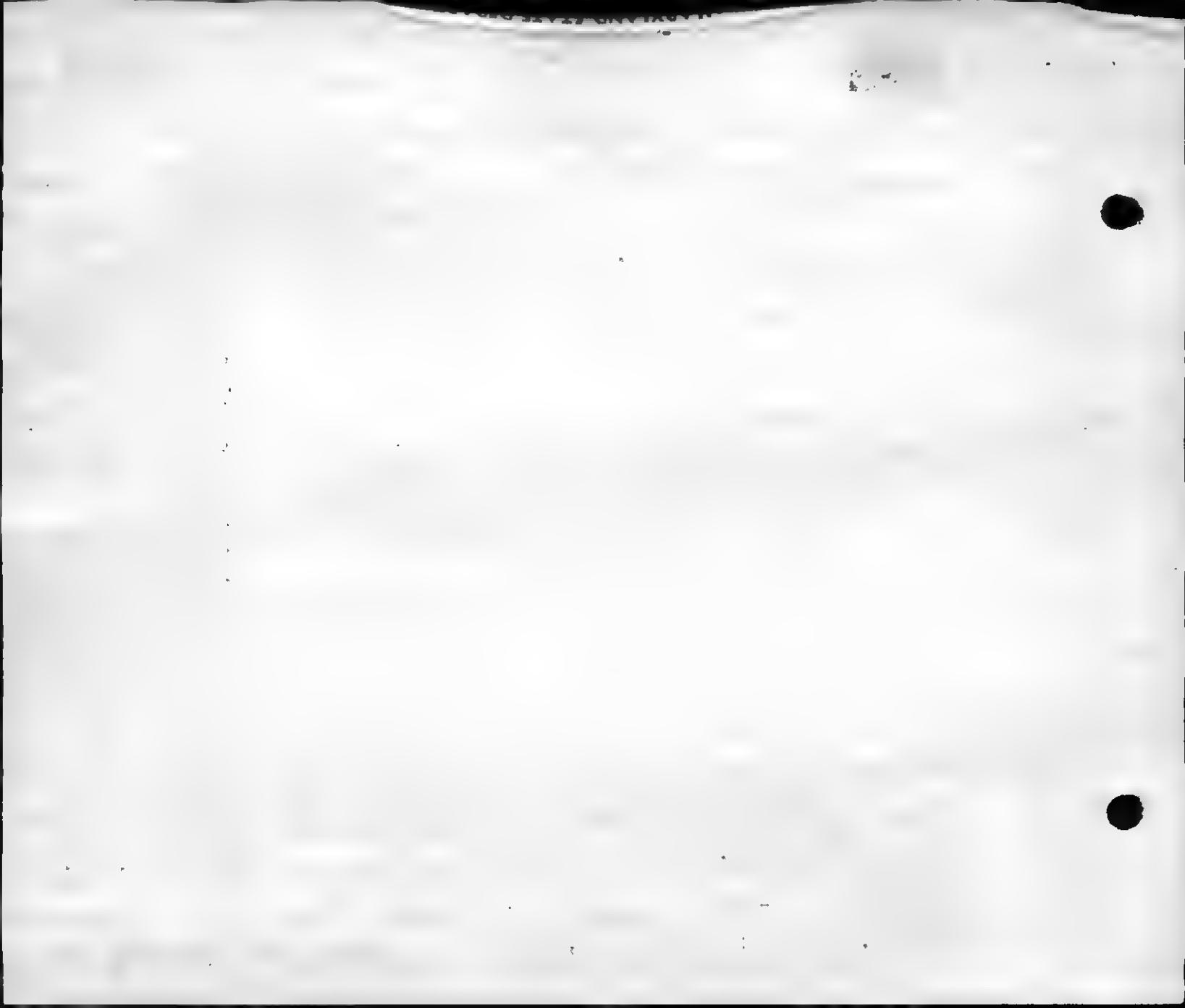
Items 18-21 fill in  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

18631

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18631

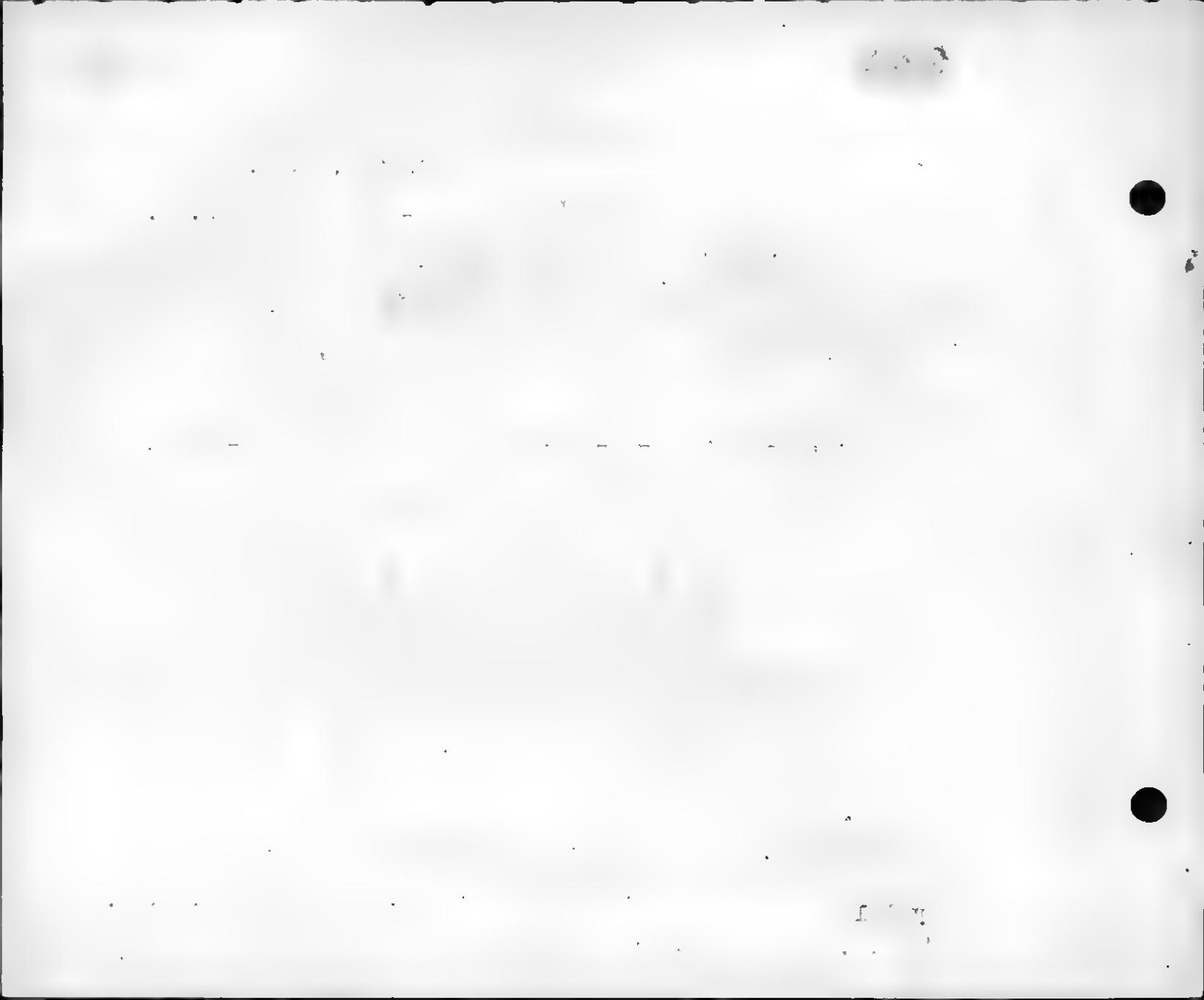
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY		a. STATE	
Montgomery		Md	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Bethesda		Montgomery	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
DoA		5057 Bradley Blvd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Suburban		Chevy Chase	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Margaret		4. DATE OF DEATH	
First		Month	
V.		Day	
Middle		Year	
5. SEX		5. COLOR OF RACE	
F		W	
6. MARRIED		7. NEVER MARRIED	
<input type="checkbox"/>		<input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years last birthday)	
Feb. 9, 1911		55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Clerical.		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.A.		James Franklin Adams	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)	
Wallace E. Hodson, formerly Kd		16. SOCIAL SECURITY NO.	
Unknown		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) / Drug intoxication		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO		18 hr?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Over dose of barbiturates and alcohol		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
DUE TO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
} (c)		Took over dose of drugs and alcohol.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20c. TIME OF INJURY Month, Day, Year	
20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour e.m. 6/26 19 66		20f. (City or town) (County) (State)	
p.m. <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
JOHN G. BALL		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial-transit		22c. NAME OF CEMETERY OR CREMATORIAL	
6-28-66		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
ROBERT A. PUMPHREY, Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE JUN 30 1966	
Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #7 Film #100-6724160-100											
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b Olney			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY		
Montgomery MARYLAND											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brookgrove Foundation (Sharon)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C.					
3. NAME OF DECEASED (Type or print) Elizabeth			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX female			6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/1895	9. AGE (in years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Payroll clerk			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Louisville, Kentucky			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Phillip Heuser			14. MOTHER'S MAIDEN NAME Lenora Schmidt								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) no			16. SOCIAL SECURITY NO. 579-05-9662			17. INFORMANT Nursing Home Records-Olney, Maryland			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH 3 day					
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			(b) <i>Parkinson disease</i>						5 yrs		
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 18, 1966</i> to <i>JUNE 15, 1966</i> , that (I) (we) last saw the deceased alive on <i>JUNE 15, 1966</i> , and that death occurred at <i>1000 15th Street, Washington, D.C.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Ed. Duval</i>									22b. DATE SIGNED <i>1966</i>		
22c. PHYSICIAN'S NAME (Type) <i>Ed. Quigley M.D.</i>			22d. ADDRESS <i>1223 15th Street, Washington, D.C.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/20/66			23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery			23d. LOCATION (City, town or county) (State) Washington, D. C.		
24. FUNERAL DIRECTOR The S. H. Hines Company Washington, DC			ADDRESS			25a. REC'D BY REGISTRAR JUN 17 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
						DATE					

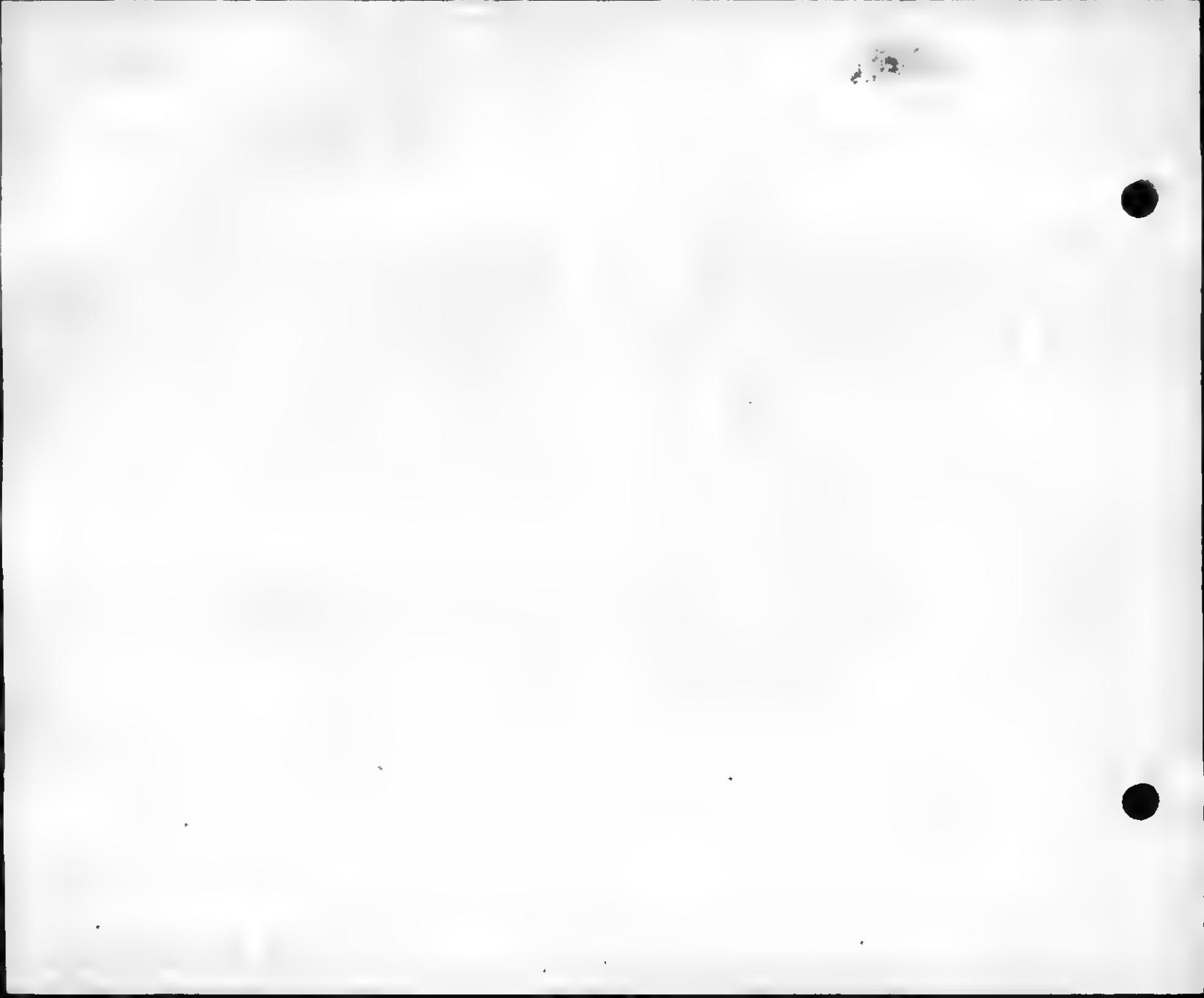


To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)									
a. COUNTY <b>MONTGOMERY</b>				a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY (N) in <b>7 hrs 5 min</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hosp. or Silver Spring</b>								d. STREET ADDRESS <b>Box 1013 Middlebrook Rd</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print)			First <b>Baby Giel</b>	Middle <b>H</b>	Last <b>HOLMES</b>	4. DATE OF DEATH <b>JUNE 17 1966</b>	Month <b>JUNE</b>	Day <b>17</b>	Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/17/66</b>		9. AGE (in years last birthday) <b>8 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS Days <b>20</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY Co. MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harless L. Holmes</b>				14. MOTHER'S MAIDEN NAME <b>BETTY Wilson</b>				Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Harless L. Holmes - same as #2 above</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)				DUE TO Resulting (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>6-17 1966</b> to <b>6-17 1966</b> , that (I) (we) last saw the deceased alive on <b>6-17 1966</b> , and that death occurred at <b>5:50 PM</b> , from the causes and on the date stated above.				22b. DATE SIGNED <b>6-17-66</b>									
22a. SIGNATURE <b>Raymond J. Gibbons</b>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <b>Raymond J. Gibbons</b>				22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/20/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Memorial</b>				23d. LOCATION (City, town or county) (State) <b>Annapolis Md.</b>					
24a. FUNERAL DIRECTOR <b>Bevelley E. Hopping</b>		ADDRESS <b>Beverley E. Hopping</b>		25a. REC'D BY REGISTRAR <b>JUN 21 1966</b>				25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
VR A15 (4) 15M 4-64													



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08634

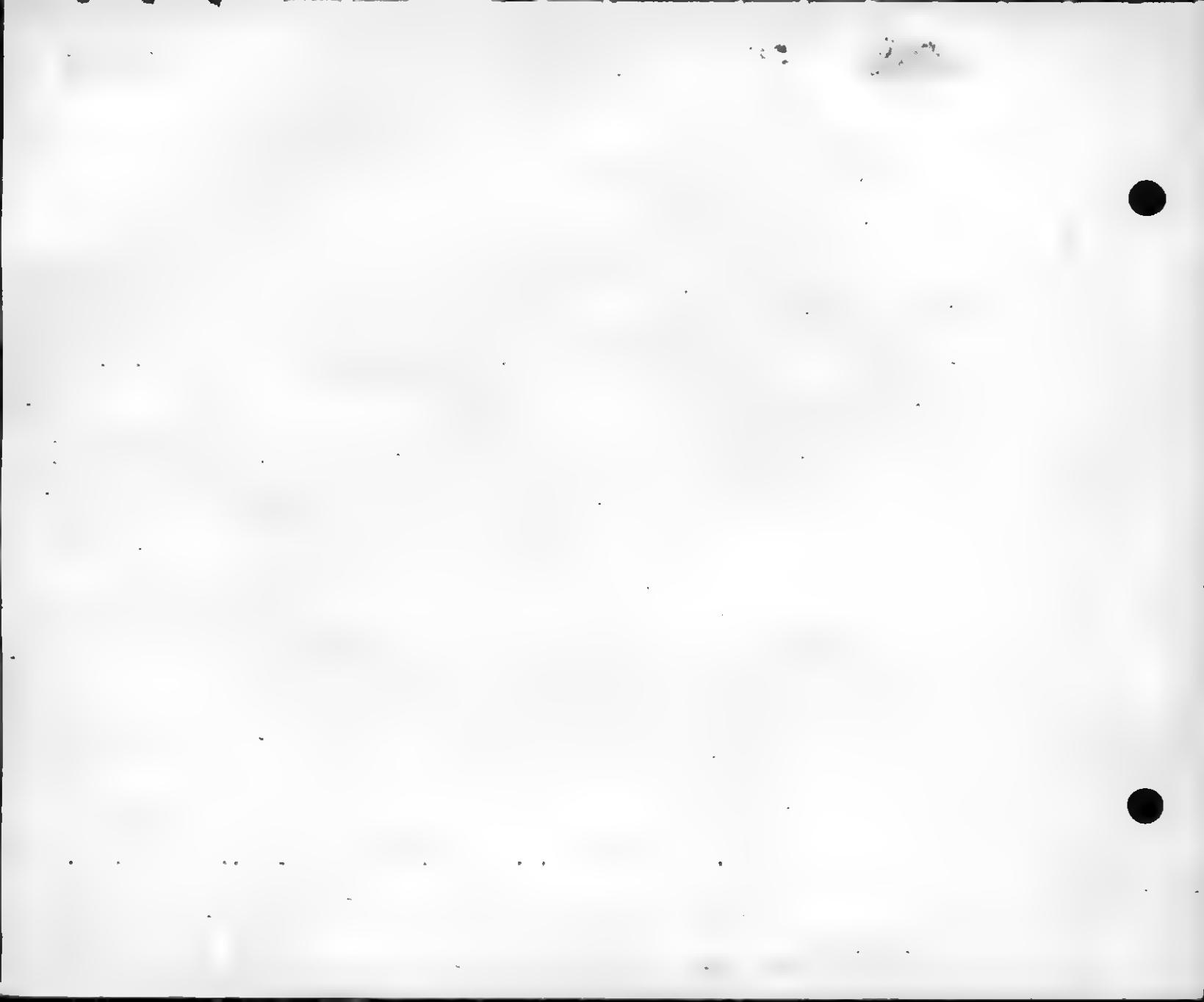
08644

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it may be returned to the hospital or attending physician.

10 **11** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21** **22** **23** **24** **25** **26** **27** **28** **29** **30** **31** **32** **33** **34** **35** **36** **37** **38** **39** **40** **41** **42** **43** **44** **45** **46** **47** **48** **49** **50** **51** **52** **53** **54** **55** **56** **57** **58** **59** **60** **61** **62** **63** **64** **65** **66** **67** **68** **69** **70** **71** **72** **73** **74** **75** **76** **77** **78** **79** **80** **81** **82** **83** **84** **85** **86** **87** **88** **89** **90** **91** **92** **93** **94** **95** **96** **97** **98** **99** **100** **101** **102** **103** **104** **105** **106** **107** **108** **109** **110** **111** **112** **113** **114** **115** **116** **117** **118** **119** **120** **121** **122** **123** **124** **125** **126** **127** **128** **129** **130** **131** **132** **133** **134** **135** **136** **137** **138** **139** **140** **141** **142** **143** **144** **145** 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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY Montgomery	
Silver Spring		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
12506 Dalewood Drive		12506 Dalewood Drive	
3. NAME OF DECEASED (Type or print)		First	Middle
James		Garfield Houk Houk	
4. DATE OF DEATH		Month	Day Year
June 29 1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
October 3, 1881		84 yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
Ret. Inspector		National Tube Co.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John B. Houk Houk		Nancy Nimmo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No None		Yes	
17. INFDRMANT		Address	
Clarence H. Burgraff		12506 Dalewood Dr. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		7 Terminal Pulmonary Cavern	
3-1X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Clerks - Muscular Acedent	
		DUE TO (c) Cutaneo - sclerotic	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		13 days 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/16/66</u> to <u>6/29/66</u> , 1966, that (I) (we) last saw the deceased alive on <u>6/27/66</u> , and that death occurred at <u>Hospital</u> M, from the causes and on the date stated above.		22d. DATE SIGNED <u>6/29/66</u>	
22a. SIGNATURE <u>Francis X. Richardson</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Francis X. Richardson, M.D.		11412 Viers Mill Rd., Wheaton, Md. 20901	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF	
Burial		July 2, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
Harmony Baptist Church		Lawrence Co., Pennsylvania	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
John B. Thomas, Jr. & Sons, Inc.		25b. REGISTRAR'S SIGNATURE	
8434 Georgia Ave., Silver Spring, Md.		Charles Judge	
Warren E. Pumphrey, Inc.		DATE JUL 5 1966	



1 TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

08645

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08635

1. PLACE OF DEATH  
2. COUNTY

MONT. COUNTY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

TAKOMA PARK

c. LENGTH OF STAY IN 1b

3 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WASHINGTON SANITARY & HOSPITAL

3. NAME OF  
DECEASED  
(Type or print)

First  
ANNA  
Middle  
CAROLYN

Last  
HUNTER

4. DATE  
OF  
DEATH  
JUNE  
20  
1966

5. SEX

6. COLOR OR RACE

WHITE

7. MARRIED  
WIDOWED

NEVER MARRIED  
DIVORCED

8. DATE OF BIRTH

AUG 12 1976

9. AGE (in years  
last birthday)

89 yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

GERMANY

12. CITIZEN OF WHAT  
COUNTRY?

AMERICAN

13. FATHER'S NAME

JOHN ELLERBROCK

14. MOTHER'S MAIDEN NAME

ANNA ALHEIT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

UNKNOWN

17. INFORMANT

Address

HOSPITAL RECORDS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

4200

DUE TO

Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO

(c)

Cerebral Failure secondary to  
Arteriosclerotic Heart Disease, advanced.

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Cerebral Arteriosclerosis - Generalized Arteriosclerosis

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

(County) (State)

factory, street, office bldg., etc.)

20f. (City or town)

(County) (State)

Hour a.m.

p.m.

White

Not White

at work

at work

at work

at work

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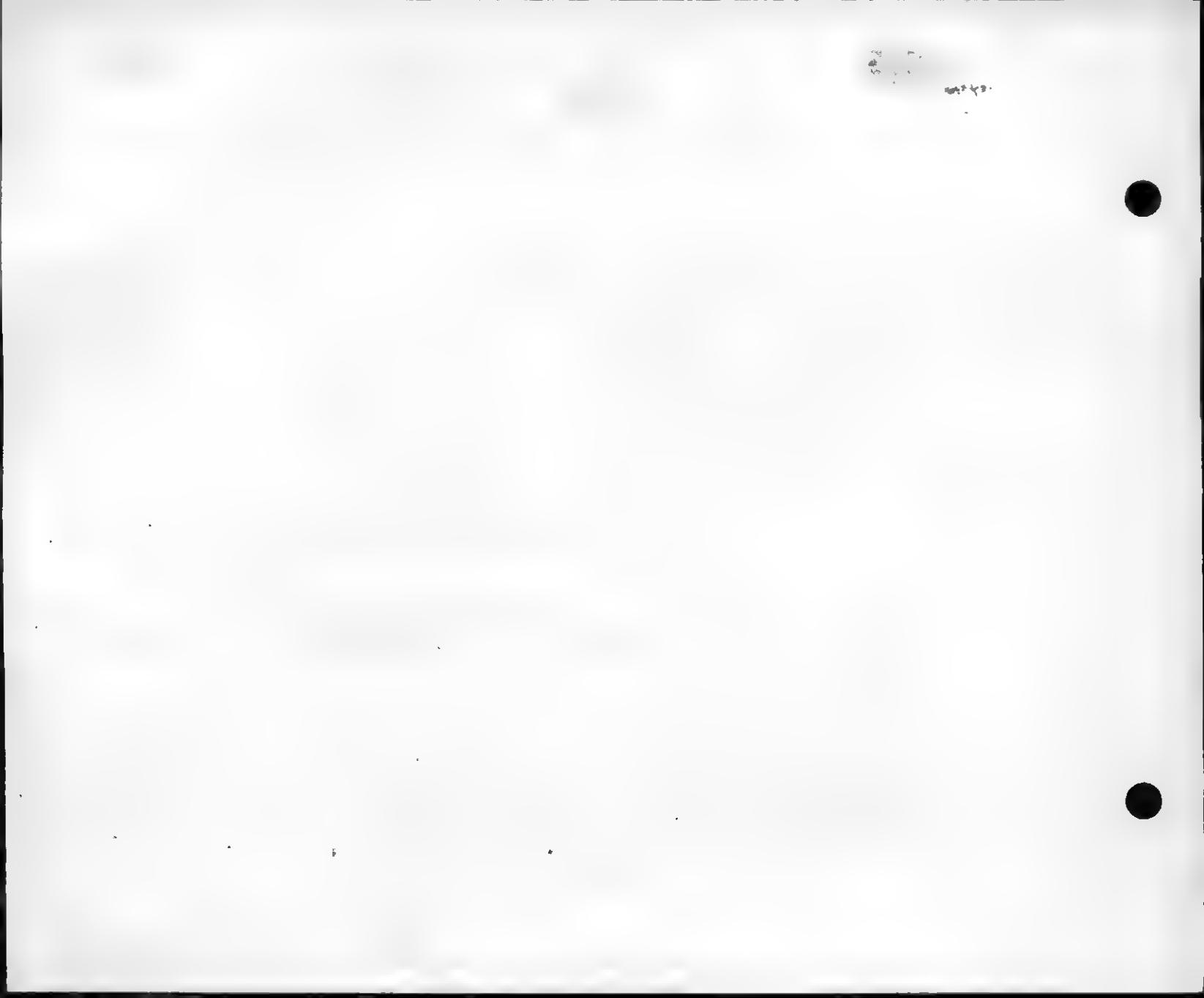
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

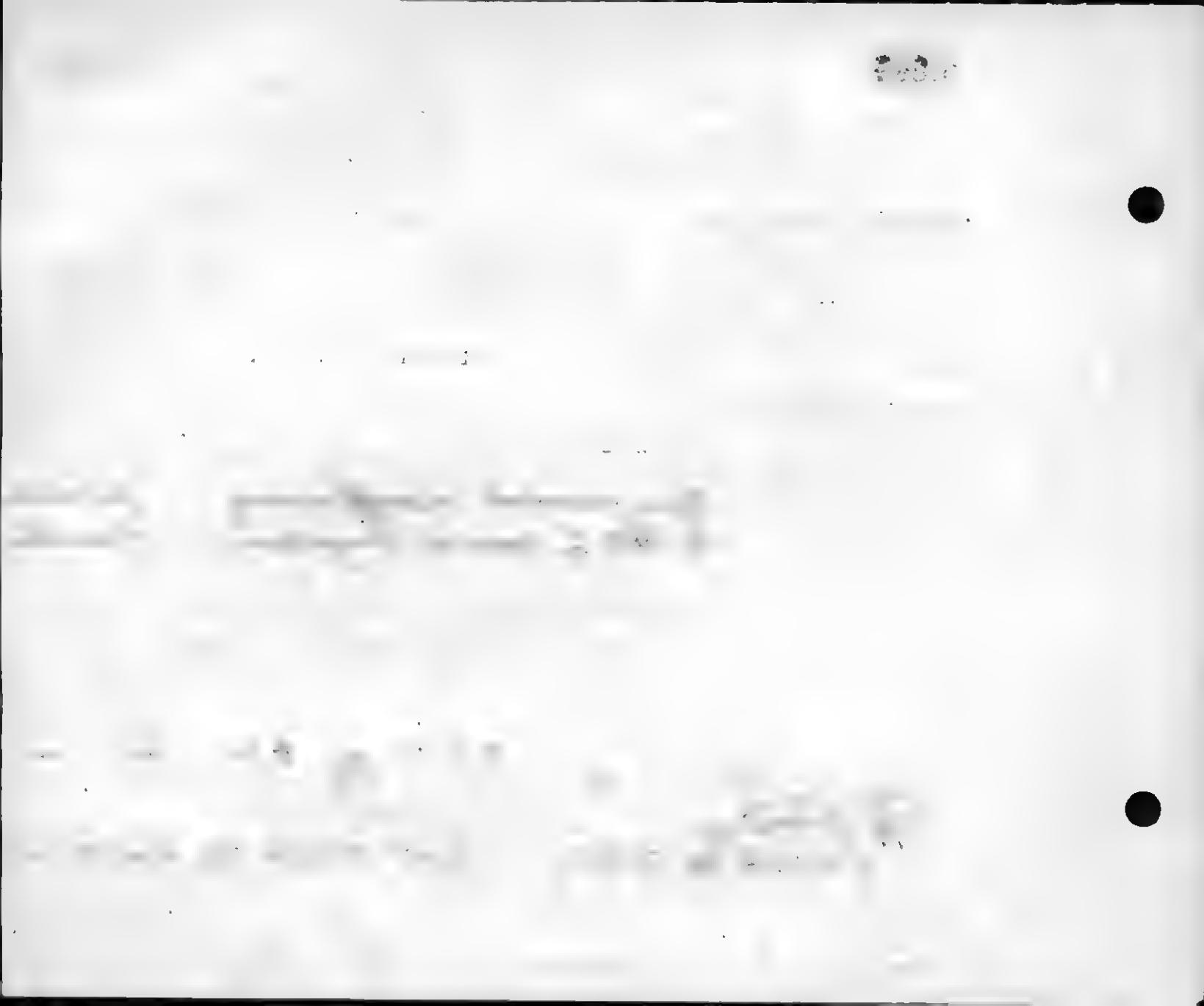
## CERTIFICATE OF DEATH

08636

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 weeks</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>605 Silver Spring Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ERNEST</b>		First <b>TEMPEL</b>		Middle <b>HUTCHINSON</b>		4. DATE OF DEATH <b>June 10 1966</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/22/1879</b>		9. AGE (In years last birthday) <b>86 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Frederick Hutchinson</b>		14. MOTHER'S MAIDEN NAME <b>Rose Riely</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>227-46-0753</b>		17. INFORMANT <b>J. C. Hutchison</b>		Address <b>1000 S. Woodstock St Arlington, Virginia</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b>		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>			
A.S.H.D. & passive congestion						4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3/15/1966</b> to <b>6/10/1966</b> , that (I) (we) last saw the deceased alive on <b>6/7/1966</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.		22b. DATE SIGNED							
22a. SIGNATURE 		22b. DATE SIGNED <b>3/15/1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>HUGH W. IREY</b>		22d. ADDRESS <b>7105-Riggs Rd, Hyattsville</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/12/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Newland Baptist Church</b>		23d. LOCATION (City, town or county) (State) <b>Richmond County, Virginia</b>			
24. FUNERAL DIRECTOR <b>John W. Morris</b> Arlington Funeral Home		25a. RECEIVED BY REGISTRAR <b>JUN 14 1966</b>							
		25b. REGISTRAR'S SIGNATURE <b>Charles Juoy</b>							



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #2 3 &amp; 8 Film #333 8/24/66 pc

98647

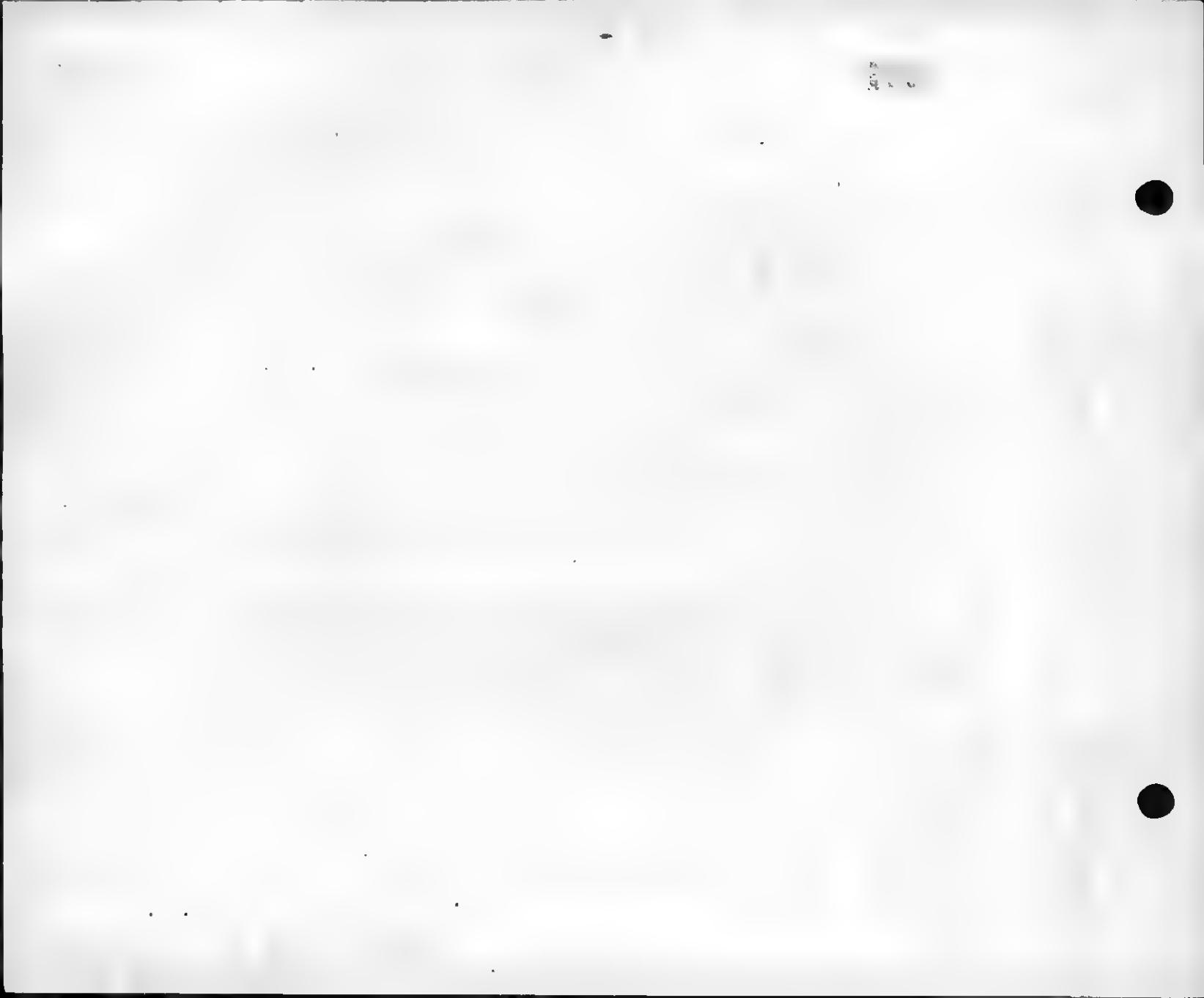
## CERTIFICATE OF DEATH

08637

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~if you have carbon papers~~ and ~~and then~~ file this certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE Maryland b. COUNTY Alleg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) C. and Petersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carol Hall Sanitarium 10231 Carol Place		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARA		Bro. M. d. Lost Breather		4. DATE OF DEATH June 19, 1966	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 24, 1897	9. AGE (In years last birthday) 50 1/4 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Petersburg, W. Va.	
13. FATHER'S NAME Francis Wilbur Breather		14. MOTHER'S MAIDEN NAME Laura Bell Hutton		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 211-05-6940		17. INFORMANT Jane' Hutson Meigs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CV				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 4 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>14 June 1966</u> , that (I) (we) last saw the deceased alive on <u>25 May 1966</u> , and that death occurred at <u>5</u> M, from causes and on the date stated above.					
22a. SIGNATURE <i>Horace W. Berntson</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/14/66	
22c. PHYSICIAN'S NAME (Type) HORACE W. BERNTSON		22d. ADDRESS 4743 Bradley Blvd, Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Removal		23b. DATE THEREOF 6/17/66		23c. NAME OF CEMETERY OR CREMATORIUM Maple Hill Cem.	
24. FUNERAL DIRECTOR Sorley-Wheatley Funeral Home, Alexandria, Va.		ADDRESS		25a. RECEIVED BY REGISTRAR JUN 16 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

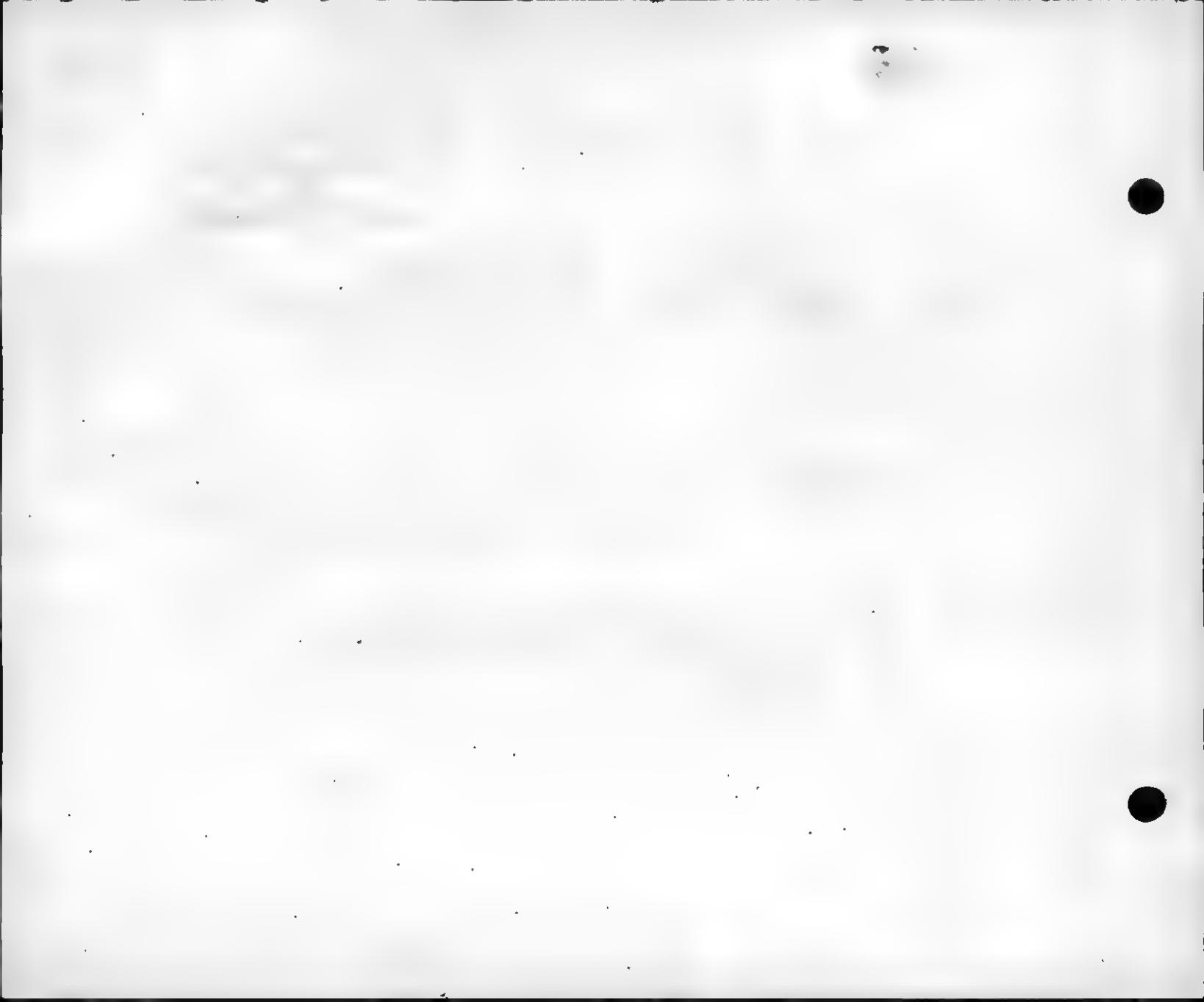
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b <b>16 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS</b>		d. STREET ADDRESS <b>10307 Julep Ave</b>	
3. NAME OF DECEASED (Type or print) <b>DOROTHY</b>		First <b>W</b>	Middle <b>IRWIN</b>
4. DATE OF DEATH <b>6 12 1966</b>		Last <b>6</b>	Month <b>Month</b>
5. SEX <b>F</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>4-23-88</b>		9. AGE (In years last birthday) <b>78 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK A. ADAMS</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES BYRNES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>EDWARD J. MARYES</b>		Address <b>10307 JULEP AVE. SILVER SPRING, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Carcinoma Colon; Metastasized to Liver and Peritoneum</i> <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Osteoporosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)
20f. (City or town) <b>(County)</b> <b>(State)</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1966</b> to <b>June 12, 1966</b> that (I) (we) last saw the deceased alive on <b>6/12/66</b> and that death occurred at <b>545 M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>6/12/66</b>	
22a. SIGNATURE <i>John J. Curry MD</i>		22d. ADDRESS <b>10620 Georgia Ave Silver Spring MD</b>	22b. ATTENDING M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>W. W. CHAMBERS Co.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE THEREOF <b>6-15-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>CALVARY CEM.</b>	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS Co. RIVERDALE, MD.</b>		25a. REC'D BY REGISTRAR <b>JUN 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. J. J.</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08649

## CERTIFICATE OF DEATH

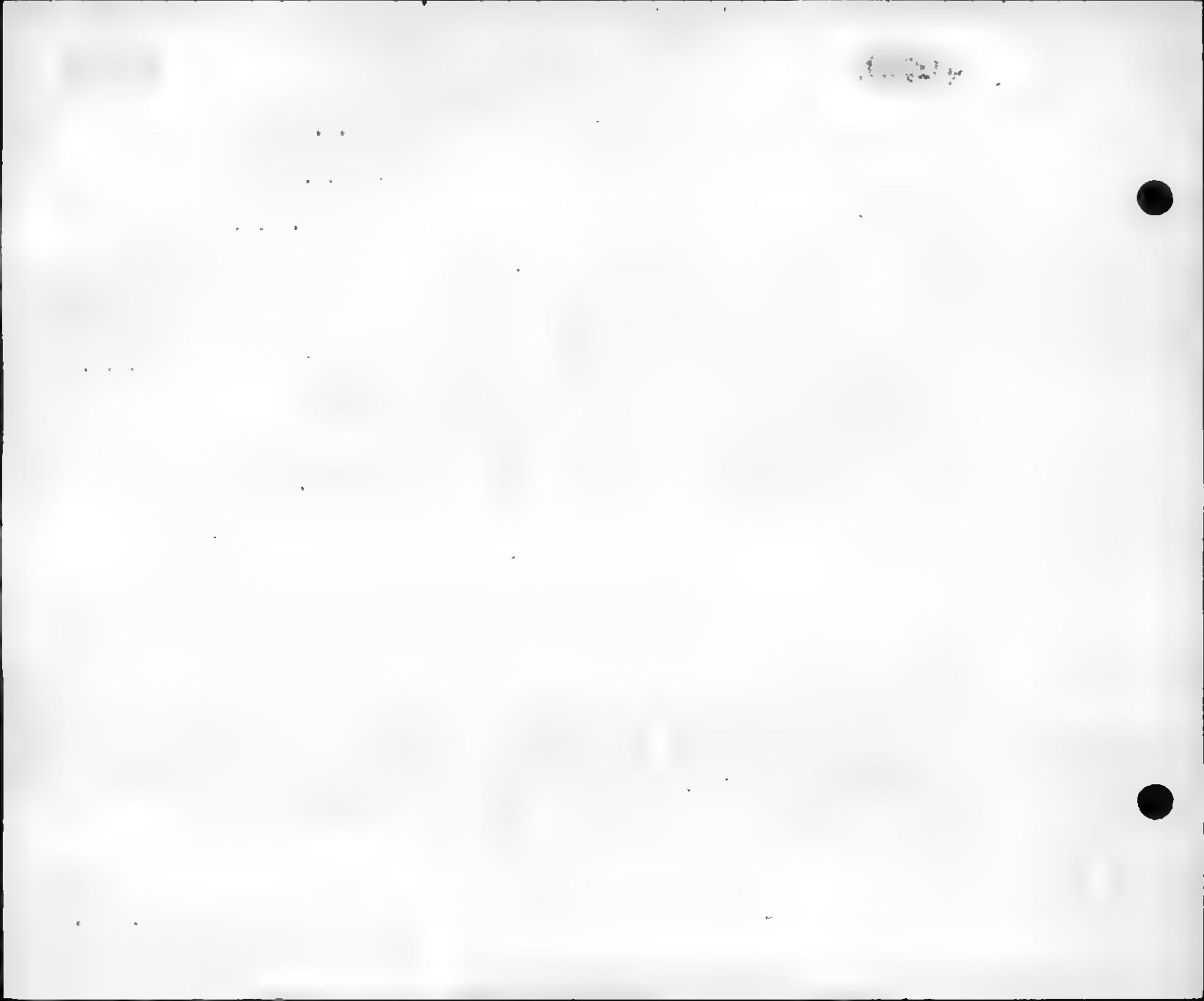
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Washington D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b 33 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>		d. STREET ADDRESS <i>3409 Wheeler Rd. S.E.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Addie</i>		First (NMN) <i>Jackson</i>	Middle Last Month Day Year June 16 19 66
S. SEX <i>female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>7-22-28</i>		9. AGE (In years last birthday) <i>37 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Porter Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Mamie Patterson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Patient's chart</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>154X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Carcinomatosis, periton. cavity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Infest. obstruction, full bowel</i>	
DUE TO (b) DUE TO (c) <i>Cancer of recto sigmoid</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ALL DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1966</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>5-15</i> , 1966, to <i>6-16</i> , 1966, that (II) (we) last saw the deceased alive on <i>5-16</i> , 1966, and that death occurred at <i>4:30 AM</i> from causes and on the date stated above			
22a. SIGNATURE <i>John T. Rhodes Jr.</i>		22b. DATE SIGNED <i>6-16-66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-20-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Harmony Memorial Pk.</i>
23d. LOCATION (City or Town) (County) (State)		23e. REG. BY REGISTRAR DATE <i>PRINCE GEORGES, MD. JUN 22 1966</i>	
24. FUNERAL DIRECTOR <i>John T. Rhodes Jr.</i>		25b. REGISTRAR'S SIGNATURE DATE <i>Charles Judge</i>	
25a. ADDRESS <i>3015-14 st. NE</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c &amp; d File #3378 6/12/66 DC

## CERTIFICATE OF DEATH

08630

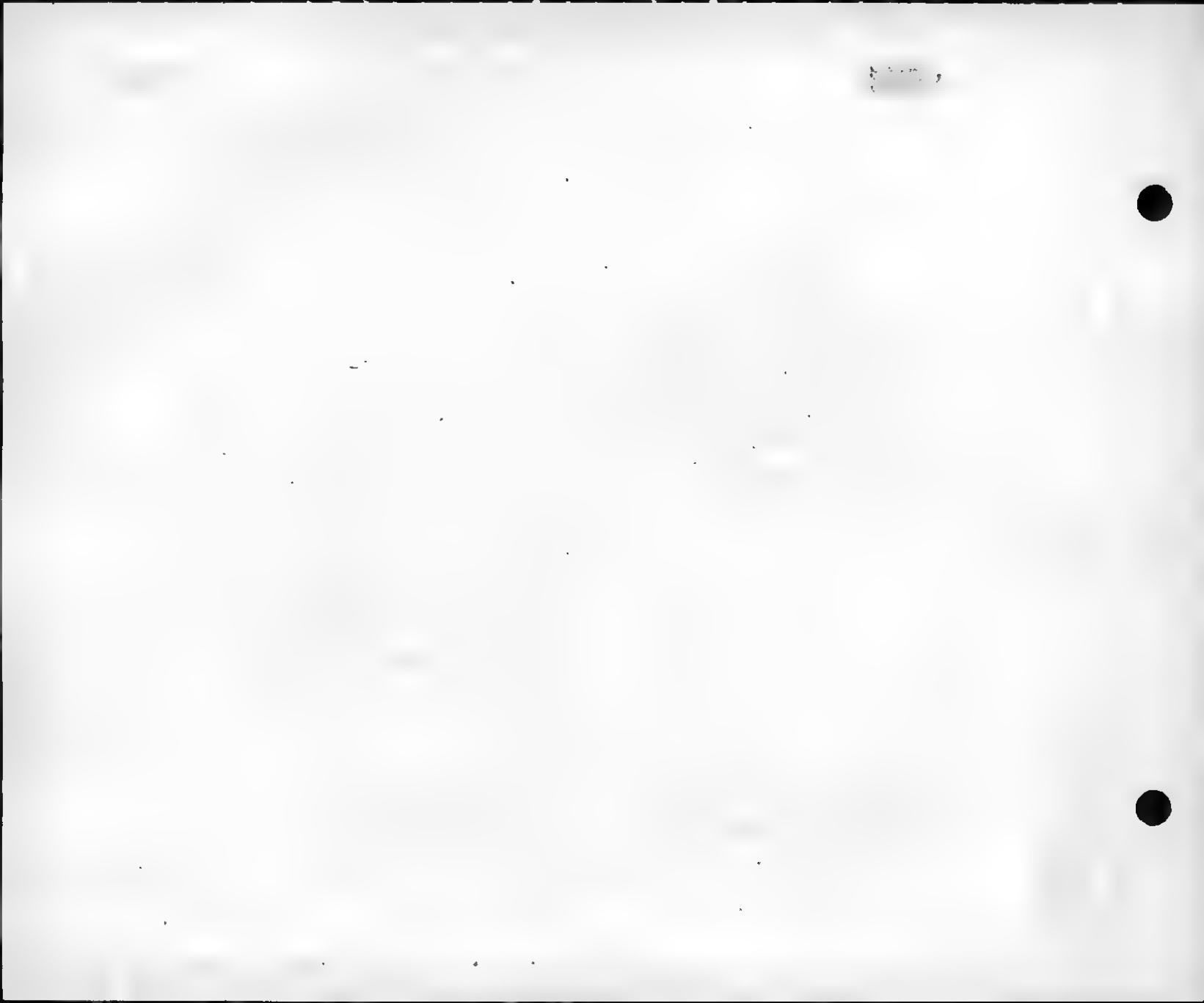
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1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if instit. on. Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Rural, Germantown, Md.</i>		<i>Wheaton</i> Germantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Home</i>		Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Aline</i>	Middle <i>Ellen</i>	Last <i>Jackson</i>
4. DATE OF DEATH	Month <i>July</i>	Day <i>7</i>	Year <i>1966</i>
5 SEX <i>fm</i>	6 COLOR OR RACE <i>col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>March 17-1908</i>
9. AGE (In years last birthday) <i>58 yrs</i>	10. UNDER 1 YEAR <i>2</i>	11. UNDER 1 MONTH <i>22</i>	12. UNDER 24 HRS <i>-</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>	10b KIND OF BUSINESS OR INDUSTRY <i>Homes</i>	11 BIRTHPLACE (County & State, or foreign country) <i>Daneonville, W. Va.</i>	12 CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13 FATHER'S NAME <i>Clarence Henry Mc. Donald</i>	14 MOTHER'S MAIDEN NAME <i>Julia Mae Clipper</i>	Address <i>James E. Jackson, R2, Germantown, Md.</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16 SOCIAL SECURITY NO <i>578-03-6256</i>	17 INFORMANT <i>James E. Jackson, R2, Germantown, Md.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident, left hemiplegia</i>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>High arterial tension, adiposity</i>	DUE TO (b) <i>High arterial tension, adiposity</i>	DUE TO (c) <i>years</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1961-1966</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.m. <i>June 7-1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7 Brooks Ave, Gaithersburg, Md.</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April 14-1965</i> , to <i>June 7-1966</i> that (I) (we) last saw the deceased alive on <i>June 7-1966</i> , and that death occurred at <i>9:30 PM</i> from causes and on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <i>June 14, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>William C. Miller</i>	22d. ADDRESS <i>7 Brooks Ave, Gaithersburg, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/12/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Seneca Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Seneca, Md.</i>
24. FUNERAL DIRECTOR <i>Robert L. Sorenson</i>	ADDRESS <i>Rockville, Md.</i>	25a. REC'D BY REGISTRAR <i>June 14, 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judy</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

08651

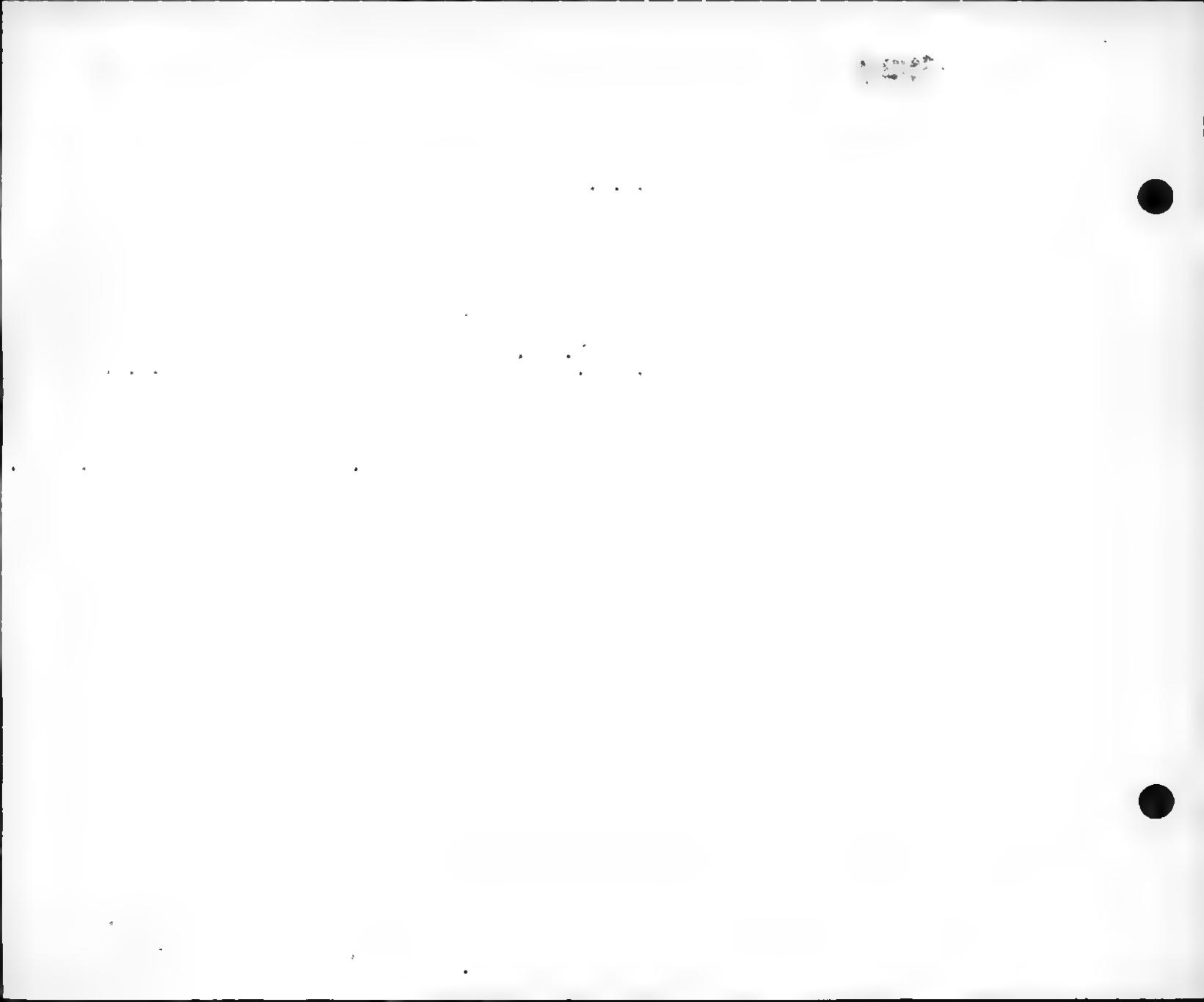
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118641

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. It goes along with the State Department of Health or its designated agent, prior to burial, cremation, or removal, on any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Rockville.		c. LENGTH OF STAY IN 1b D.C.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban 627 N. Horners Lane.		e. STREET ADDRESS Hanson Drive	
3. NAME OF DECEASED (Type or print) John Wesley Jackson		First John	Middle Wesley
4. DATE OF DEATH Month June Day 21 Year 1966		5. LAST JACKSON	6. DATE OF BIRTH 12-12-1923
7. MARRIED W. DIVORCED M. C.		8. NEVER MARRIED W. DIVORCED M. C.	9. AGE (in years last birthday) 42 yrs
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Refuse Collector		10b. KIND OF BUSINESS OR INDUSTRY Wash. Sub. San. Comm.	10c. BIRTHPLACE (State or foreign country) Maryland
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MOTHER'S MAIDEN NAME Mary Dimes	
13. FATHER'S NAME John Wesley Jackson		14. MOTHER'S MAIDEN NAME Mother - Mrs. Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother - Mrs. Jackson		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fatty metamorphosis Liver	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John W. Bell MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6/21/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/25/66	23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park
23d. LOCATION (City or Town) Rockville, Md.		(County) (State)	
23e. FUNERAL DIRECTOR Robert L. Litz		23f. ADDRESS Rockville, Md.	23g. REC'D BY REGISTRAR JUN 23 1966
23h. REGISTRAR'S SIGNATURE Charles Judge		23i. REGISTRAR'S SIGNATURE Charles Judge	



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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08652

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08642

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Washington	Middle Gibson	Last Jackson	4. DATE OF DEATH June 1966
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1902	9. AGE (In years last birthday) 63 yrs.	10. UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Worker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY USA
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13. FATHER'S NAME Addison Jackson	14. MOTHER'S MAIDEN NAME Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Julia Brooks, Simpsonville, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)	19. INTERVAL BETWEEN ONSET AND DEATH Acute Coronary Insufficiency Coronary Artery Heart Disease.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
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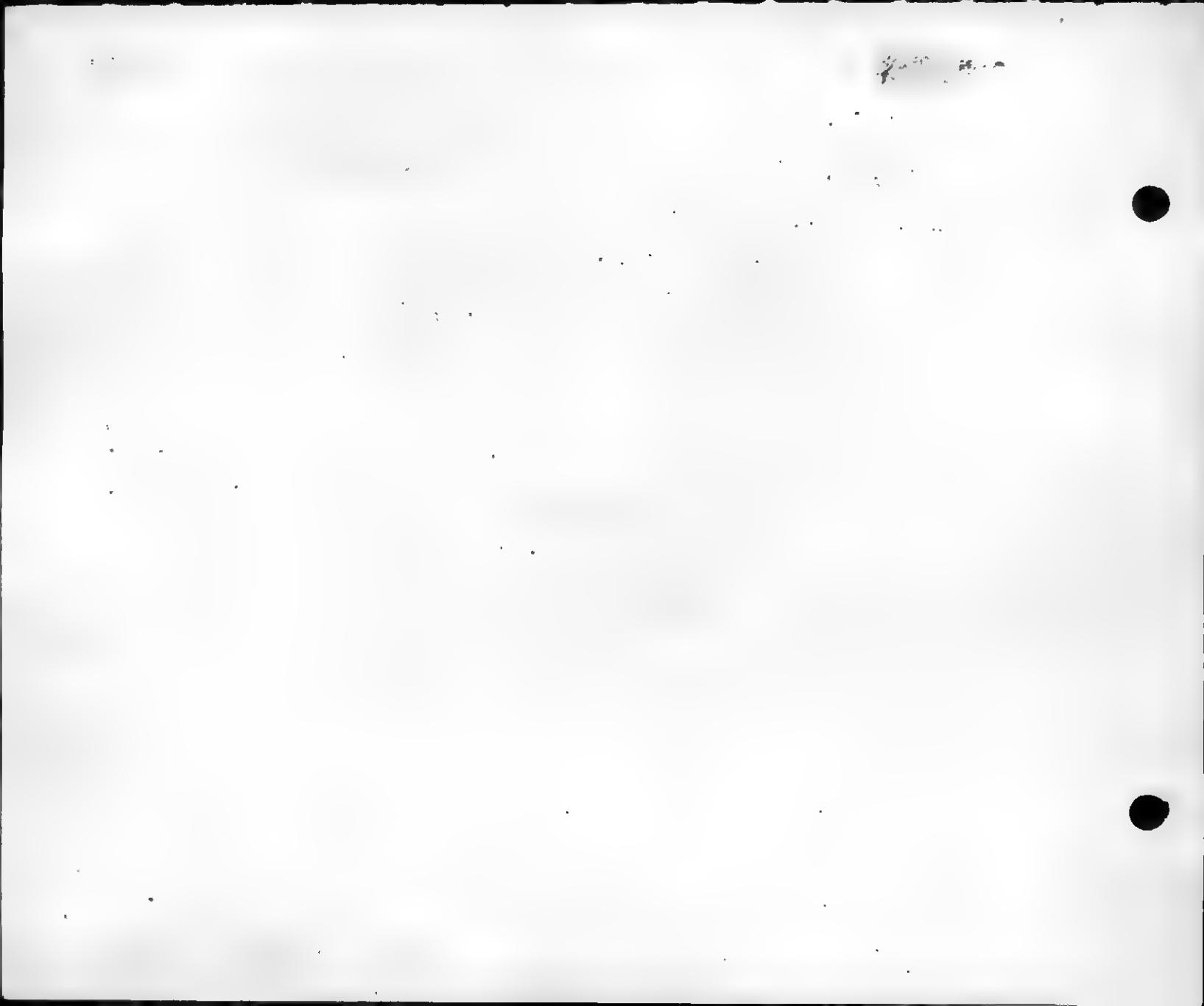
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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ACTUAL SIGNATURE BELDEN R. REAP EXAMINER'S NAME (Type)	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County)	22. DATE SIGNED 6/2/66
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF June 6, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Locust Ch. Cem.	23d. LOCATION (City, town or county) Simpsonville, Md. (State)
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24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.	ADDRESS	25a. REC'D BY REGISTRAR JUN 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08658

08643

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN MD <b>5 MONTHS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Point</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens SANITORIUM</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Catherine</b>	Middle <b>JENKINS</b>	4. DATE OF DEATH Month Day Year <b>JUNE 15 1966</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 28 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Howe</b>		14. MOTHER'S MAIDEN NAME <b>Mary McQuade</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>3504 Fathering Dr., Md. Mrs. Frances McMahan-Daughtr, Wheaton</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>49 Sepsis</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>49</b> <b>hip fx + Decubitus</b>	
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>5 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Cerebral arterio Sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1966</b> to <b>June 1966</b> , that (I) (we) last saw the deceased alive on <b>6/19/66</b> 1966, and that death occurred at <b>12 M</b> , from the causes and on the date stated above.		22d. DATE SIGNED <b>6/15/66</b>	
22a. SIGNATURE <b>Marvin Wadler</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Marvin WADLER</b>		22d. ADDRESS <b>8218 Wise Av. Bethesda</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/17/1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Ghost Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Issue, Maryland</b>	
24. FUNERAL DIRECTOR <b>Richard Funeral Home Inc. Lodi, Lodi, Lodi</b>		25a. REC'D BY REGISTRAR <b>John 17 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

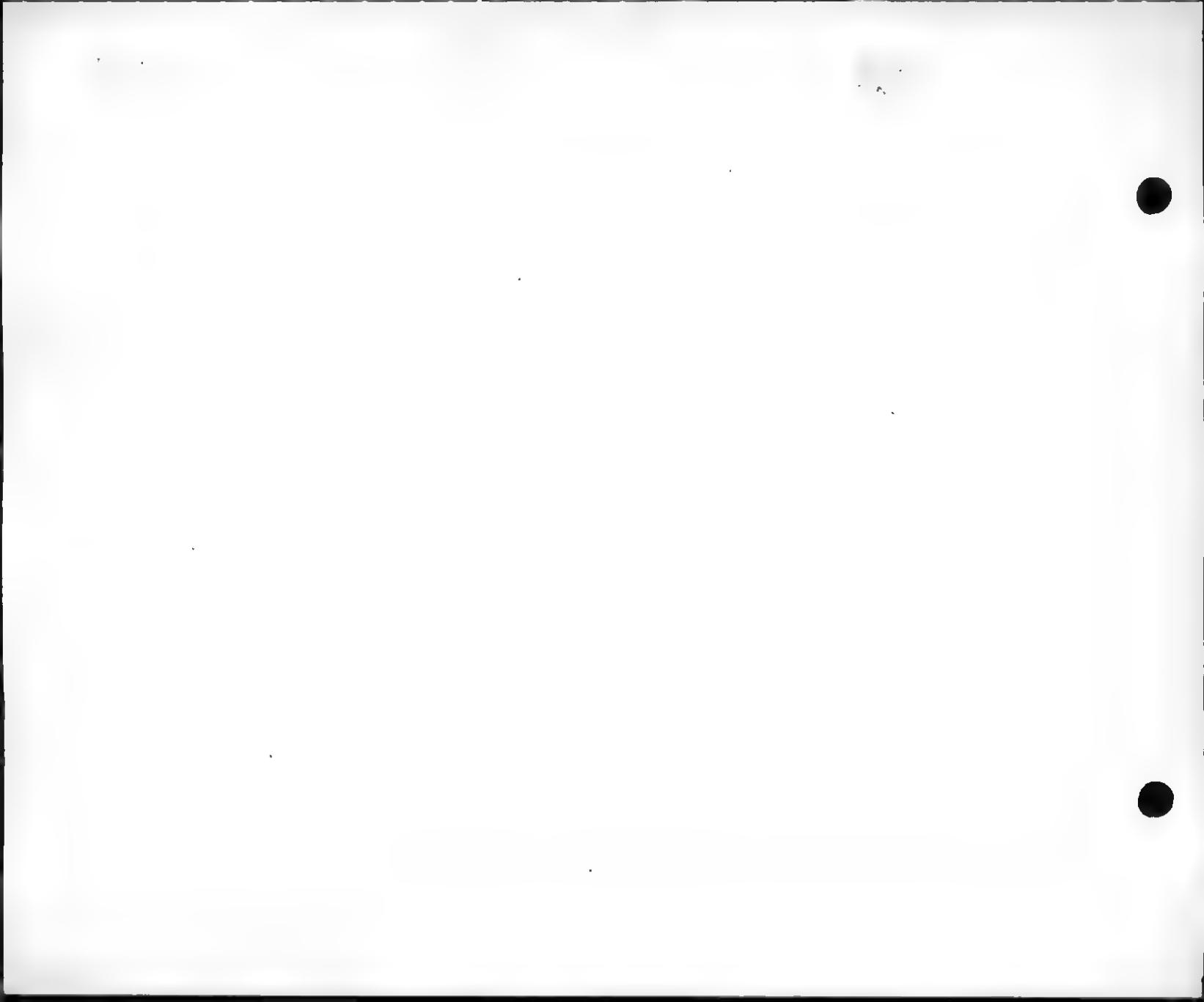
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02654

118644

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; Hosp.</b>		d. STREET ADDRESS <b>1011 Fairland Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>DAVID</b>	Middle <b>JOHNSON</b>	4. DATE OF DEATH <b>6 - 24 1966</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-30-1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Johnson</b>		14. MOTHER'S MAIDEN NAME <b>WILKINSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Blanche Ponderster</b> 1011 Fairland Rd. 2-5. md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) DUE TO (c)	
As acute asphyxiation due to Aspiration of vomitus, accompanied by intestinal obstruction.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belcher R. Keap M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <i>Belcher R. Keap, M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <b>9-23-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Good Hope</i>		23d. LOCATION (City or Town) (County) (State) <b>Calverton, Md.</b>	
24. FUNERAL DIRECTOR <i>Robert L. Shook, Inc. Rockville, Md.</i>		ADDRESS	
25a. RECD BY REGISTRAR DATE <b>JUN 30 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08655

## CERTIFICATE OF DEATH

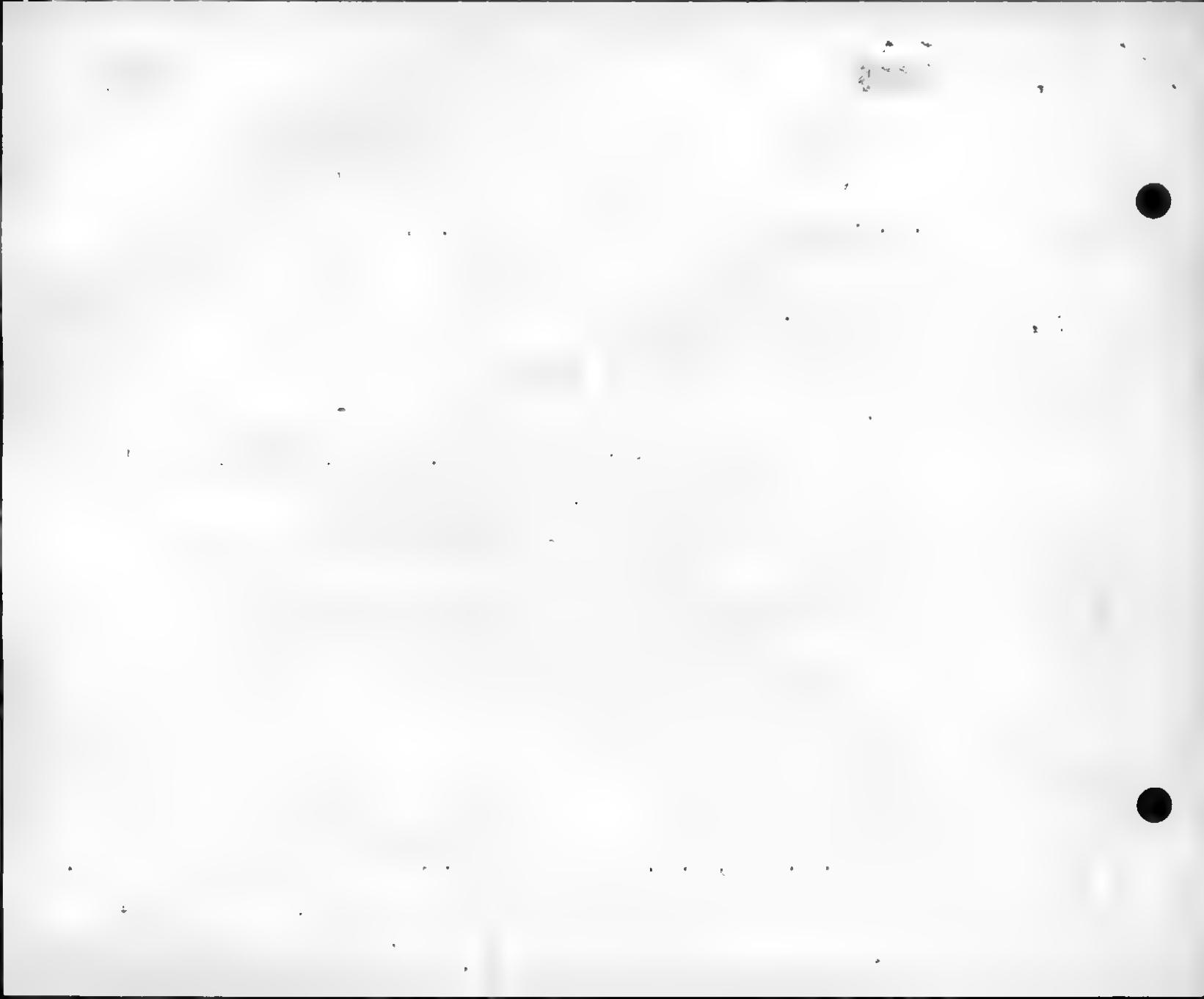
115645

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>P. O. Box 262</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Elaine</b>	Middle <b>Fern</b>	Last <b>JOHNSON</b>
4. DATE OF DEATH <b>June 13 1966</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1929</b>
9. AGE (In years last birthday) <b>37</b>	10. IF UNDER 1 YEAR Months <b>37</b>	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Columbia Falls, Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Newell H. Grant</b>		14. MOTHER'S MAIDEN NAME <b>Ella Worcester</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>not available</b>	
17. INFORMANT <b>Milton V. Johnson, Box 262, Stuart's Draft/</b>		Address <b>Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Associated acute bilateral pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last			
20. DUE TO stating the underlying cause last			
21. DUE TO stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>June 13 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Naval Hospital, Bethesda, Md.</b>
20f. (City or town) <b>Waynesboro</b>		(County) <b>Virginia</b>	
(State) <b>Virginia</b>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 1, 1966</b> , to <b>June 13, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 13, 1966</b> , and that death occurred at <b>9:45 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. L. Sugg</b>		22b. DATE SIGNED <b>14 June 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. L. Sugg, M. D.</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial transit</b>		23b. DATE THEREOF <b>June 15, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Riverview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro</b> <b>Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b>		ADDRESS <b>1557 Wisconsin Ave.</b> REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
FOR STATE  
HEALTH DEPT.

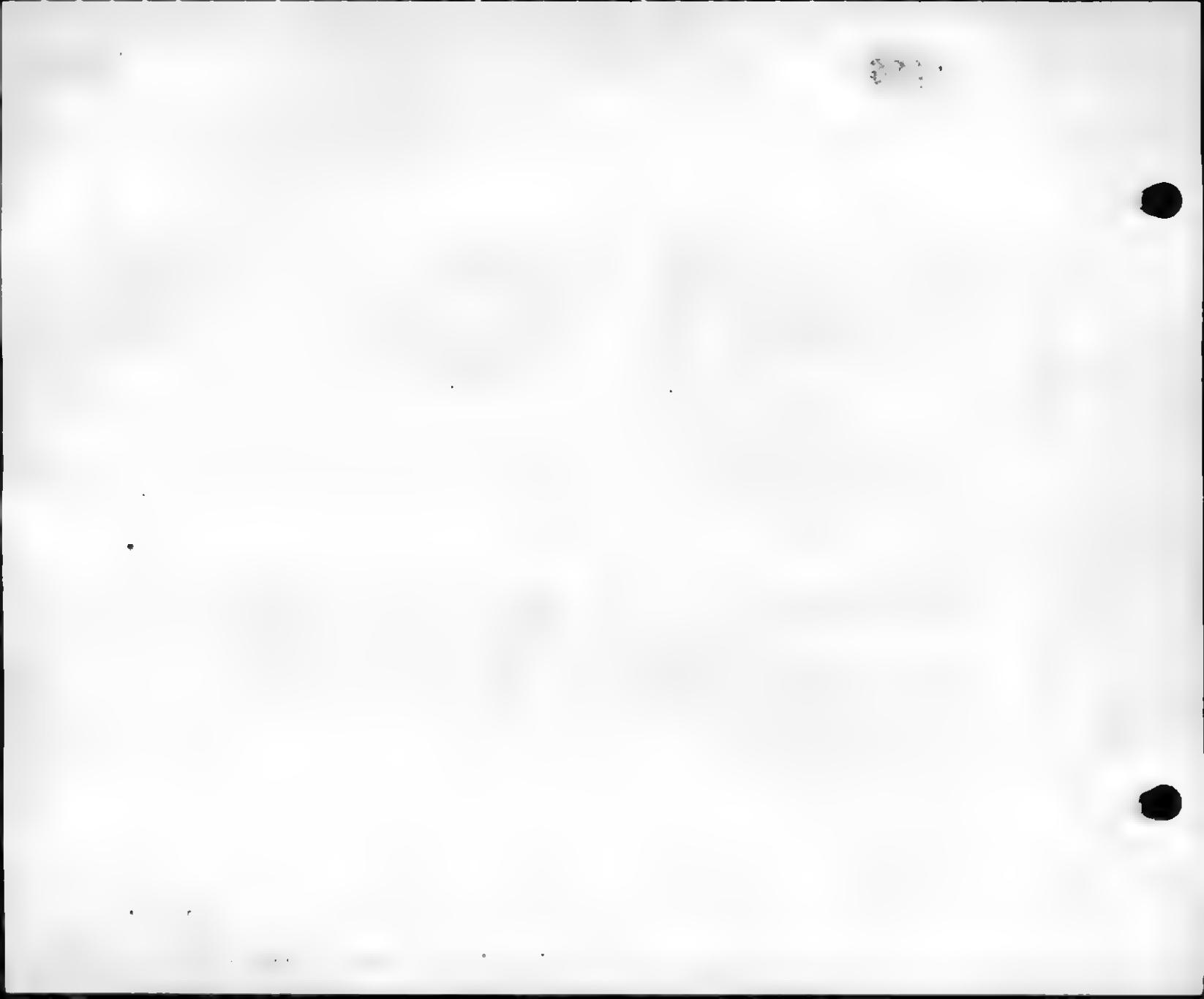
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in line 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**20656** 08646  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>		d. STREET ADDRESS <b>Box 63</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>BERNARD</b>	Middle <b>M.</b>	Last <b>JONES</b>
4. DATE OF DEATH	Month <b>JUNE</b>	Day <b>6</b>	Year <b>1966</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/21/16</b> 9. AGE (In years last birthday) <b>49 yrs.</b> 10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Boyleville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W Jones</b>		14. MOTHER'S MAIDEN NAME <b>Christy Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Army</b>		16. SOCIAL SECURITY NO. <b>123-45-6789</b> 17. INFORMANT <b>Sister -</b> <b>Edward Rd. Wash. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Fracture of Skull &amp; Massive Cerebral Injury 6 days</b>	
5535 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <b>Epileptic Seizure -</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fall - during Seizure - hitting head on Tile Floor</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2</b> p.m. <b>5/31</b> 1966		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Garage</b> 20f. (City or town) <b>Rockville</b> (County) <b>Mont.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John L. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Arlington, Va.</b>	
22. DATE SIGNED <b>6/6/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/10/66</b> 23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b> 23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		25a. ADDRESS <b>Rockville, Md.</b> 25b. REGISTRAR'S SIGNATURE <b>JUN 9 1966</b> <b>Charles Judge</b>	



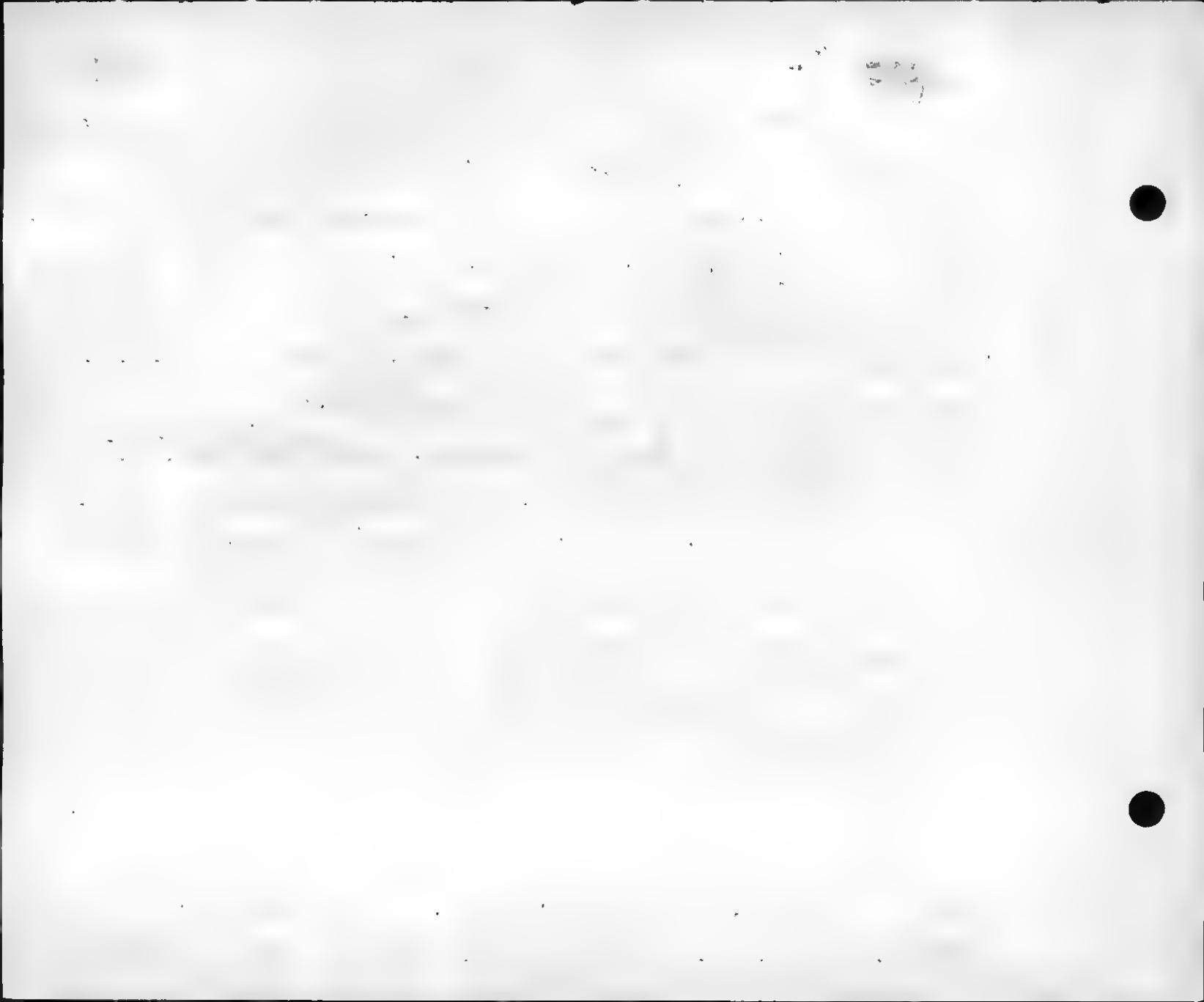
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

28557		115647	
1. PLACE OF DEATH a. COUNTY  Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium		e. STREET ADDRESS 3422 Metzerott Road	
3. NAME OF DECEASED (Type or print)  CLARA		4. DATE OF DEATH Last Month Day Year LILLIAN JONES June 21 1966	
5. SEX Female		6. COLOR DR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Divorced <input type="checkbox"/> March 27, 1878	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS DR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Columbus, Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Bruce		14. MOTHER'S MAIDEN NAME Henrietta Patten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Winston B. Jones		Address 3422 Metzerott Rd. College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Myocardial insufficiency few months ASHD & congestive heart failure 10 years.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8:00 a.m.</u> , 1966, to <u>6/21</u> , 1966, that (I) (we) last saw the deceased alive on <u>6/18</u> , 1966, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>6-21-66</u>	
22a. SIGNATURE <u>Hugh W. Irey</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Hugh W. IREY		22d. ADDRESS 7105 - RIGGS RD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Riverdale Cemetery		23d. LOCATION (City, town or county) (State) Columbus, Georgia	
24. FUNERAL DIRECTOR <u>John E. Befhornas</u> Warren E. Pumphrey, Inc.		25a. ADDRESS 8434 Georgia Avenue	
		25b. REC'D BY REGISTRAR DATE JUN 24 1966	
		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08658

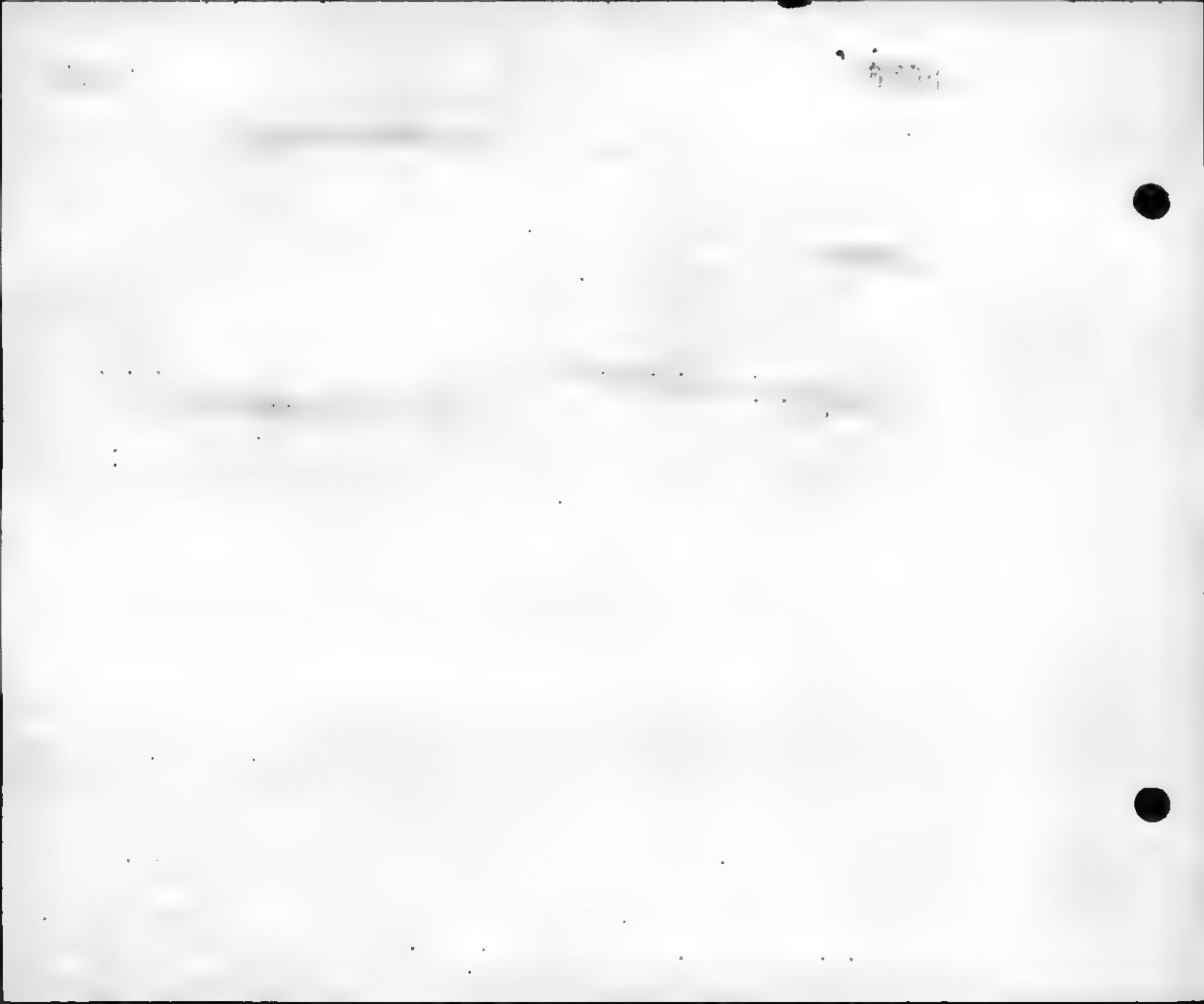
## CERTIFICATE OF DEATH

08648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 16 <i>2015 EAST West Highway</i>		c. CITY OR TOWN (If outside corporate limits, write RJR&L and give nearest town)	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Heavy Chase Nursing Home</i>		5. STREET ADDRESS <i>6521 Broad St. Brookmont, Md.</i>	
3. NAME OF DECEASED (Type of) <i>Edward C. Joss</i>		4. DATE OF DEATH Month <i>6</i> Day <i>12</i> Year <i>1966</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 28 1873</i>
9. AGE (In years last birthday) <i>93 yrs</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Retired Chief of Meat Inspection</i>	11. BIRTHPLACE (County & State or foreign country) <i>Kansas</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Gotlieb Joss</i>	14. MOTHER'S, MAIDEN NAME <i>Martha Robinette</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO <i>none</i>	17. INFORMANT <i>Merrill E. Joss</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebro Vascular Accident</i>	
DUE TO (b) <i>Cerebral Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unbekannt</i>	
DUE TO (c) <i>Generalized Atherosclerosis</i>		INTERVAL ONSET AND DEATH <i>unbekannt</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>(County) (State)</i>		20f. (City or town) <i>(County) (State)</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 25, 1965</i> to <i>Jun. 12, 1966</i> that (I) (we) last saw the deceased alive on <i>June 11, 1966</i> , and that death occurred at <i>2:20 P.M.</i> from causes and on the date stated above.			
22c. SIGNATURE <i>Stanley M. Bialek</i>		22b. DATE SIGNED <i>June 12, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stanley M. Bialek</i>		22d. ADDRESS <i>8218 Wisconsin Ave. N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		23b. DATE THEREOF <i>6/13/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Crematory</i>		23d. LOCATION (City or Town) <i>Prince Georges County, Md.</i>	
24. FUNERAL DIRECTOR <i>The S.H. Hines Co.</i>		25a. ADDRESS <i>2901 14th St. N. W. Washington, D.C.</i>	25b. RECD BY REGISTRAR <i>JUN 15 1966</i>
		25c. DATE <i>JUN 15 1966</i>	25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08659

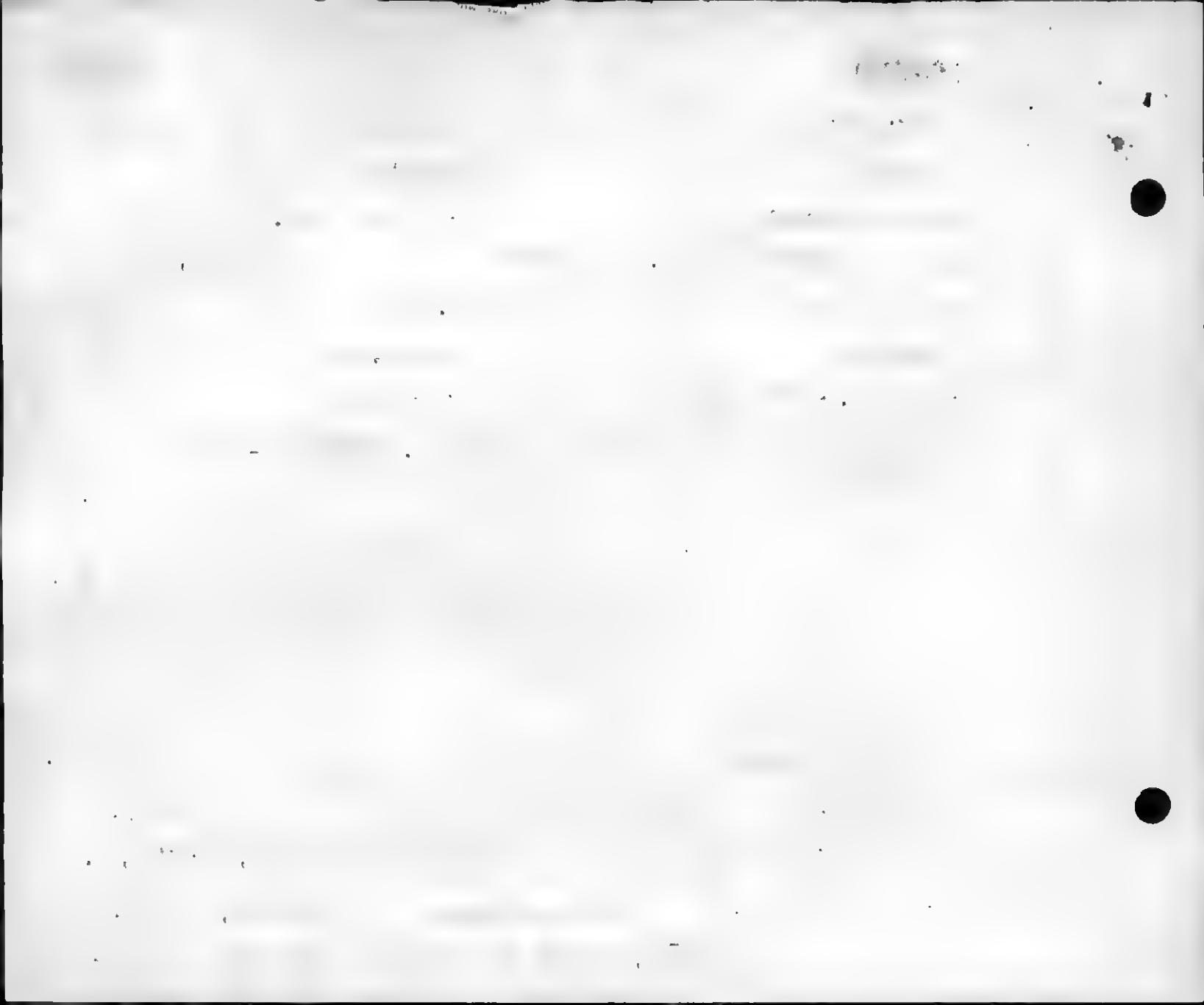
## CERTIFICATE OF DEATH

08649

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
3. NAME OF DECEASED (Type or print) <b>THEODORE</b>		First <b>D.</b>	Middle <b>KELLERBERG</b>
4. LAST <b>LAST</b>		5. DATE OF DEATH <b>June 15, 1966</b>	Month Day Year 1966 15 19
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>23 Dec. 1922</b>		9. AGE (In years last birthday) <b>43 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore A. Kellerberg</b>		14. MOTHER'S MAIDEN NAME <b>Ella Kuhns</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WW 11 Korean</b>		16. SOCIAL SECURITY NO. <b>578-18-5082</b>	
17. INFORMANT <b>Elaine G. Kellerberg - Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>OBSTRUCTIVE JAUNDICE</b> (c) <b>UNDIFFERENTIATED CARCINOMA - SITE UNKNOWN 2 MO.</b>		1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) <b>William Frank</b> attended the deceased from <b>JUN 15 1966</b> to <b>JUN 15 1966</b> , that (I) <b>never</b> last saw the deceased alive on <b>JUN 15 1966</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William Frank</b>		22b. DATE SIGNED <b>6/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Frank</b>		22d. ADDRESS <b>11125 Rockville Pike, Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/20/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>
23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>		(State)	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 20 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

08660

**CERTIFICATE OF DEATH**

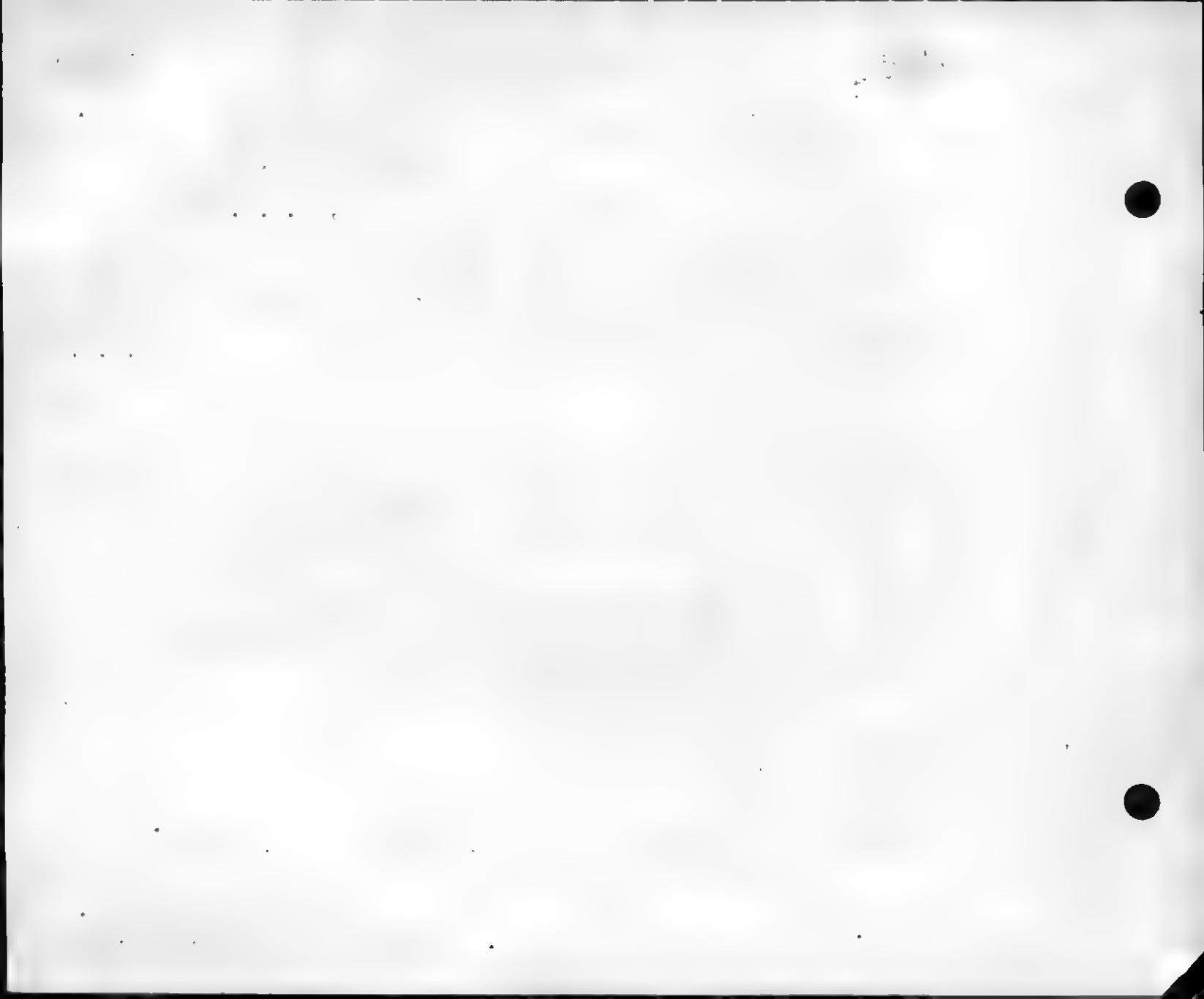
08650

Item #9 Film #0370 6/7/66 pg

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
Montgomery MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pleasantview Nursing Home		d. STREET ADDRESS Sunocown Rd, R.F.D. #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Annie	Last King	4. DATE OF DEATH Jane
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5	
1922 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2 June, 1966, that (I) (we) last saw the deceased alive on 2 June 1966, and that death occurred at 5 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 2 June 66	
22a. SIGNATURE D.A. Butler		22d. ADDRESS 2710 Norbeck Silver Spring, Md.	
22c. PHYSICIAN'S NAME (Type) D.A. Butler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL Brooke Grove		23d. LOCATION (City, town or county) (State) Laytonsville, Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR JUN 9 1966	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

11. **DO NOT ATTACH** The law requires that the death certificate be executed within 72 hours after death.

10. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



1 (M)  
FOR STATE  
HEALTH DEPT.

IN MORTUITY NOTICE: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil, in the space above, and forward to the Chief Medical Examiner's Office, Page 4 should be forwarded to the Chief Medical Examiner's Office, Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02661

118651

1. PLACE OF DEATH a. COUNTY	Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rural Laytonsville		c. LENGTH OF STAY IN 1D Years.		a. STATE Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
						Rural Laytonsville	
						d. STREET ADDRESS	
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
William	E	King		June	8	1966	
5. SEX M	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/10/1907	9. AGE (In years last birthday) 58 yrs.	10. UNDUE 1 YEAR Months	11. UNDUE 24 HRS Days	12. CITIZEN OF WHAT COUNTRY USA
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lobster-		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Charles King		14. MOTHER'S MAIDEN NAME Laura Bright					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	

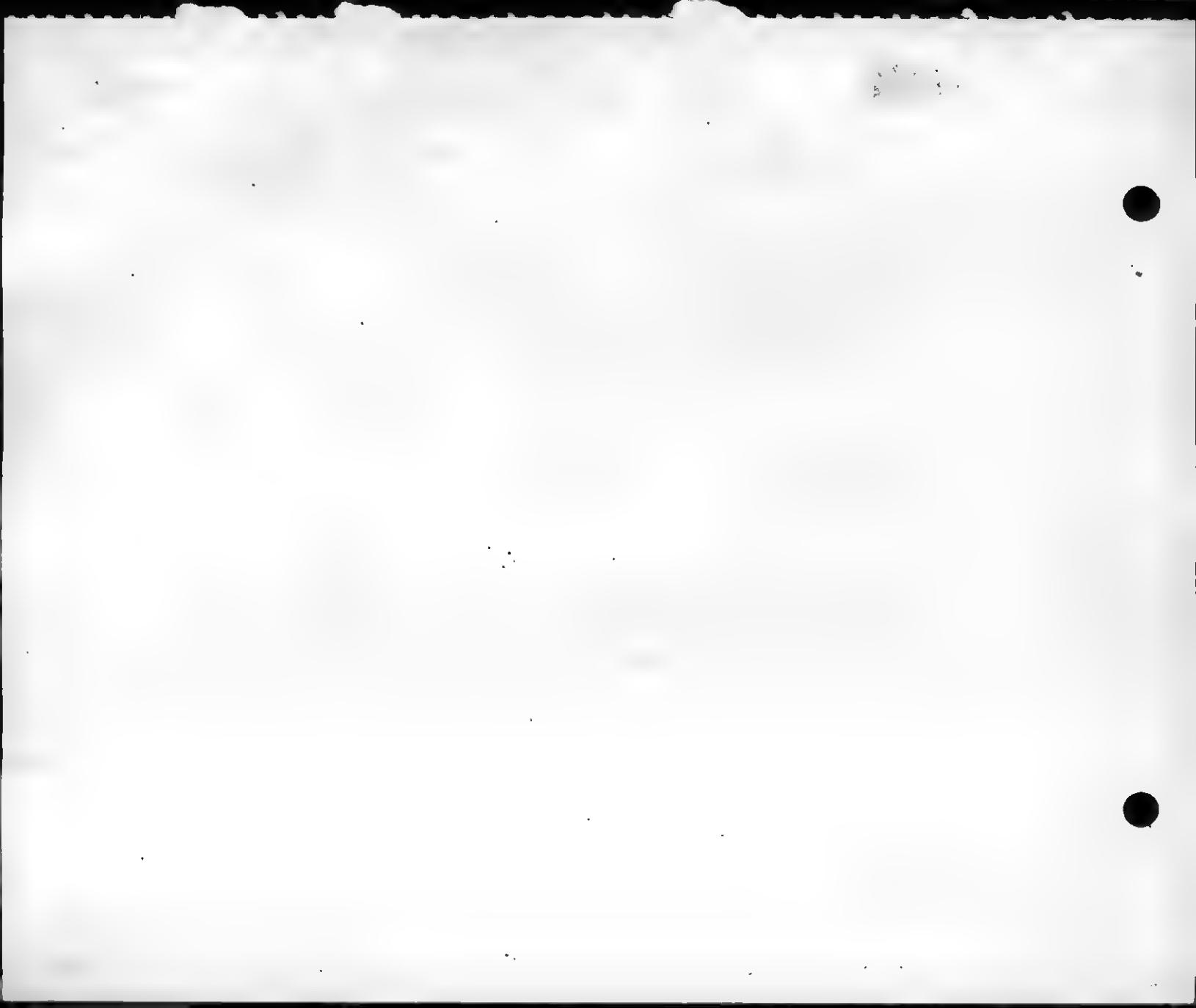
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 2 days
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) DUE TO Chronic Alcoholism		years
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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CHIEF MEDICAL EXAMINER   
M.D. ASSISTANT MEDICAL EXAMINER   
DEPUTY MEDICAL EXAMINER

ACTUAL SIGNATURE John G. Ball	22. DATE SIGNED 6/8/66		
EXAMINER'S NAME (Type)	Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/13/66	23c. NAME OF CEMETERY OR CREMATORIUM Brooke Grove	23d. LOCATION (City, town or county) Laytonsville Md.
24. FUNERAL DIRECTOR Robert L. Snowden	ADDRESS Rockville Md.	25a. REC'D BY REGISTRAR JUN 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



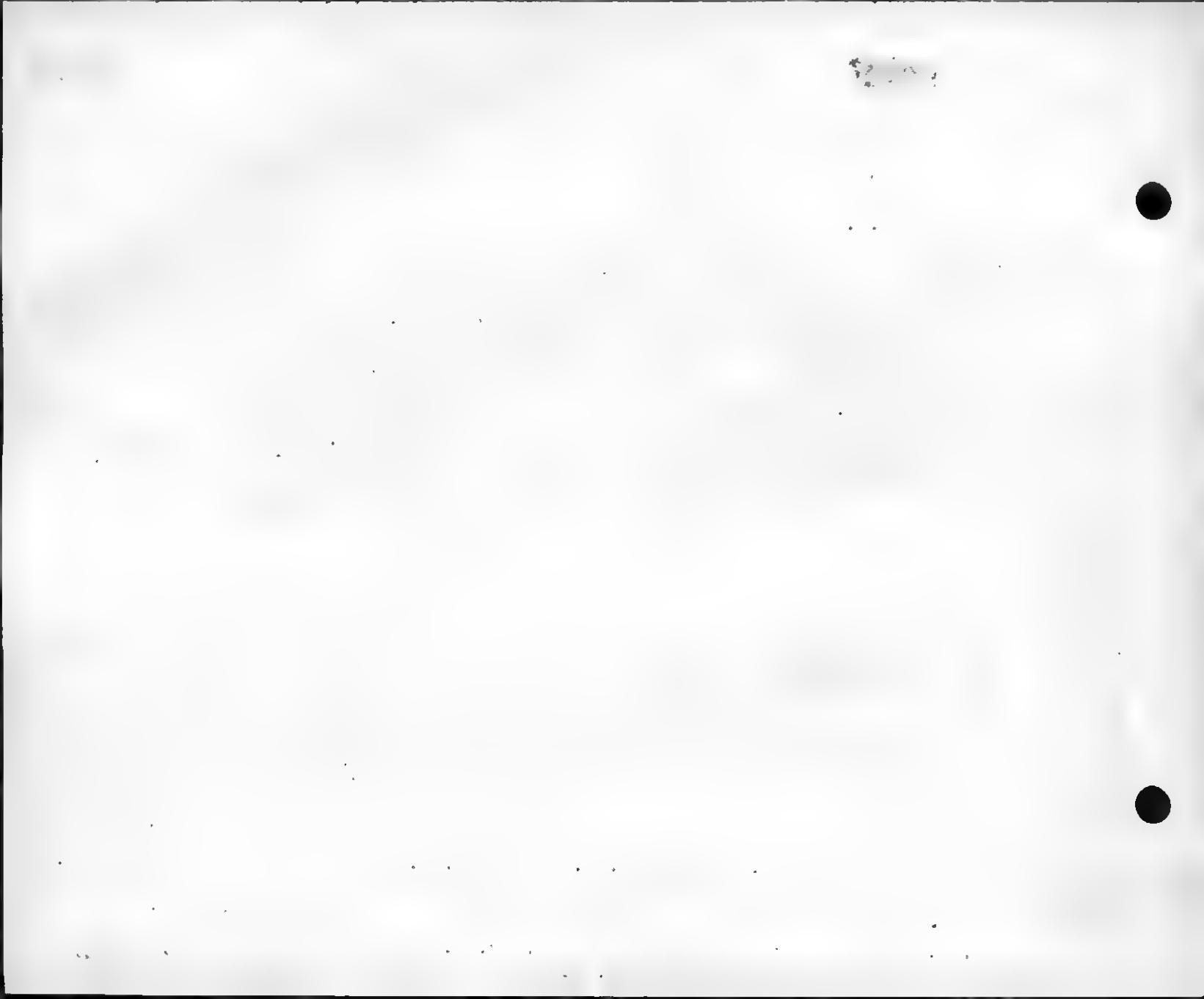
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours of death.

CERTIFICATE OF DEATH						08652			
1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 2HRS 26MINS			b. COUNTY Montgomery			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital			d. STREET ADDRESS 8385 16TH Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Kristen	Middle Drusilla	Last Kinnaird	4. DATE OF DEATH June	Month June	Day 18	Year 1966	
5. SEX Female		6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1966	9. AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS Days 15 Hours 2 Minutes 25	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) NA			10b. KIND OF BUSINESS OR INDUSTRY NA			11. BIRTHPLACE (County & State, or foreign country) Montgomery Maryland			
13. FATHER'S NAME Robert C. Kinnaird			14. MOTHER'S MAIDEN NAME Drusilla Callahan			12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NA NA			16. SOCIAL SECURITY NO NA			17. INFORMANT Robert C. Kinnaird (Father) 8385 16TH Street, Silver Springs, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Prematurity with associated atelectasis and congenital heart disease									
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO									
(c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
20. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>18 June</u> , 1966 to <u>18 June</u> , 1966, that <input type="checkbox"/> (we) last saw the deceased alive on <u>18 June</u> 1966, and that death occurred at <u>8:45 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <i>Ronald F. Swanger</i>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> June 21, 1966							
22c. PHYSICIAN'S NAME (Type) Ronald F. Swanger, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/22/66		23c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		23d. LOCATION (City or Town) Washington, D. C. (County) (State)			
24. FUNERAL DIRECTOR S. H. Hines Funeral Home, 2901 14th St., N. W. Washington, D. C.		ADDRESS S. H. Hines Funeral Home, 2901 14th St., N. W. Washington, D. C.		25a. REC'D BY REGISTRAR DATE JUN 22 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
a. COUNTY <u>MONTGOMERY</u>				a. STATE <u>MARYLAND</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				b. COUNTY <u>Prince George</u>								
c. LENGTH OF STAY IN 1b <u>4 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>3129 Beltsville, Md.</u>								
3. NAME OF DECEASED (Type or print)	First <u>MARY</u>	Middle <u>Susan</u>	Last <u>KIASE</u>	4. DATE OF DEATH	Month <u>6</u>	Day <u>1</u>	Year <u>1966</u>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-78</u>	9. AGE (In years last birthday) <u>87 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penns</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Elwood Moyer</u>	14. MOTHER'S MAIDEN NAME <u>Hulda Macorkle</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <u>No</u> <u>None</u>	16. SOCIAL SECURITY NO. <u>213-50-2936</u>	17. INFORMANT <u>Mrs. Helen M. Pisapia Beltsville</u>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) <u>Beltsville</u>		(County) <u>Prince George</u>	(State) <u>Md.</u>		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1966, to <u>May 31, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 31, 1966</u> , and that death occurred at <u>12:27</u> P.M. from the causes and on the date stated above.				22a. SIGNATURE <u>Morton Attchler</u>								
22b. DATE SIGNED <u>6-1-66</u>				22c. PHYSICIAN'S NAME (Type) <u>Morton Attchler, M.D.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	23d. LOCATION (City, town or county) <u>Rockville, Maryland</u>		(State) <u>Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 3, 1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) <u>Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24. FUNERAL DIRECTOR <u>John Thomas</u>		ADDRESS <u>8434 Georgia Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
VR A15 (4) 20M 1/65												



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08664

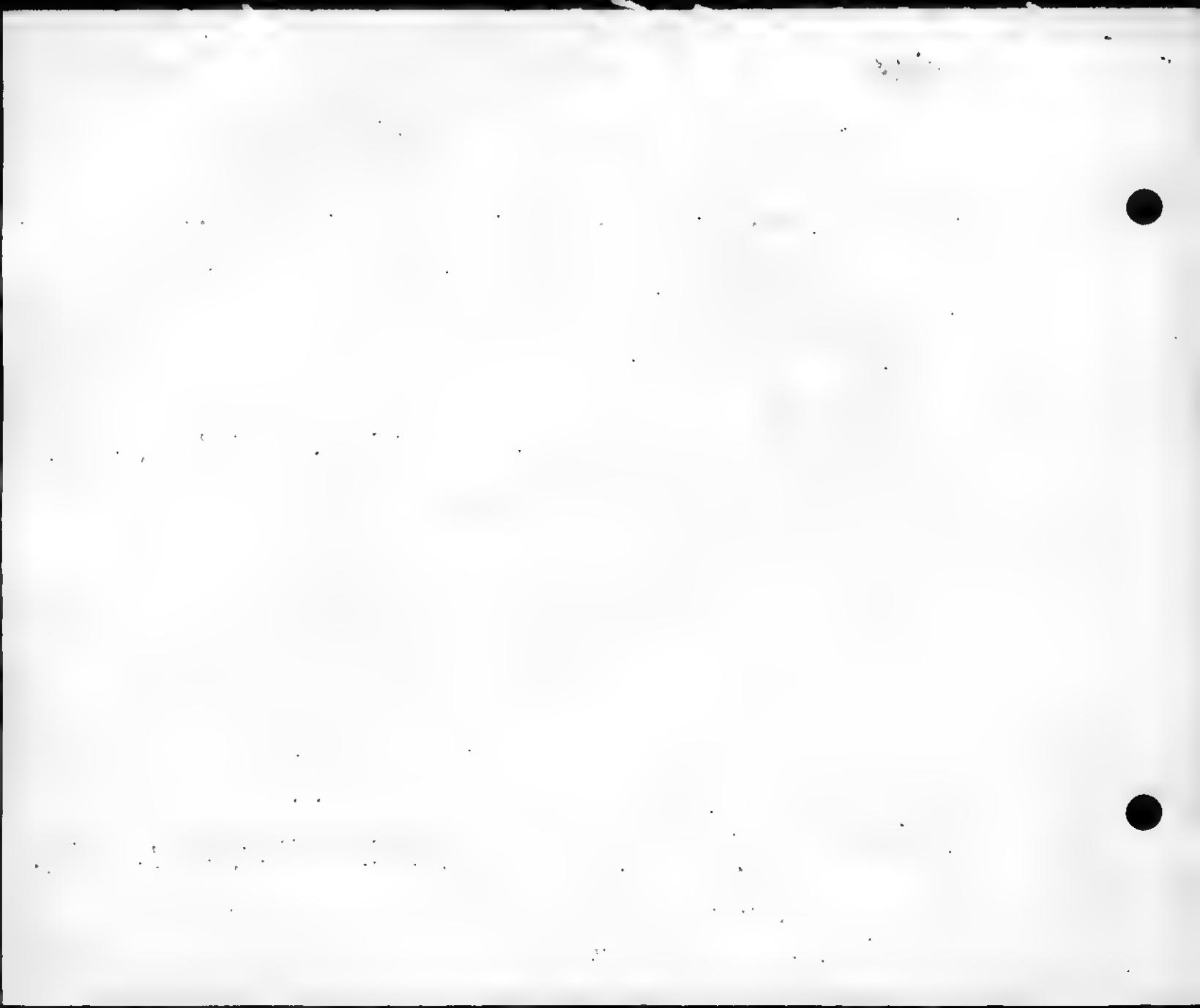
## CERTIFICATE OF DEATH

08654

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>77 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>		e. STREET ADDRESS <b>1309 - 17th Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Hiroshi</b>		First <b>Hiroshi</b>	Middle <b>David</b>
4. DATE OF DEATH <b>June 23 1966</b>		Last <b>Komuro</b>	Month <b>June</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Japanese</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			8. DATE OF BIRTH <b>6 January 1912</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Art</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Tokuji Komuro</b>		14. MOTHER'S MAIDEN NAME <b>Kane Miura</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>	
17. INFORMANT <b>The Medical Record, <sup>4448</sup> The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Reticulum Cell Sarcoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7 April 1966</b> to <b>23 June 1966</b> , that <input type="checkbox"/> (we) last saw the deceased alive on <b>23 June 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>12:20 A.M. 23 June 1966</b>	
22a. SIGNATURE <b>James H. Wells</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/25/1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Columbia Gardens</b>
24. FUNERAL DIRECTOR <b>Ives Funeral Home</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
		25b. REGISTRAR'S SIGNATURE	DATE <b>JUN 28 1966</b>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

08655

1. PLACE OF DEATH a. COUNTY <b>KOBB, HEART</b> MONTGOMERY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> (6 days)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING, MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>HENRY</b>	Middle K	Last KOBB
4. DATE OF DEATH	Month 6	Year 14	Day 19 66
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/91
9. AGE (In years last birthday) 74 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER WOOD</b>		10b. KIND OF BUSINESS OR INDUSTRY DR
11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DAVID KOBB</b>	14. MOTHER'S MAIDEN NAME <b>Naomi ?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. 306-10-5201 <b>KOBB KOBB SAME AS 2</b>		
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>			
4 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Acute coronary occlusion</b>			
DUE TO (c) <b>Hemopericardium</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6-8</b> , 19 <b>66</b> , to <b>6/14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>6/14</b> , 19 <b>66</b> , and that death occurred at <b>1324</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ira Tublin</b>		22b. DATE SIGNED <b>6/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ira Tublin, M.D.</b>		22d. ADDRESS <b>800 Pershing Drive, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Geo. Lewis Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Hyattsville Md.</b>	
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		25a. REC'D BY REGISTRAR <b>4217-9-8110</b>	
		25b. REGISTRAR'S SIGNATURE <b>JUN 17 1966</b>	

be executed within 24 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be ~~executed~~ within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FRUIT OF THE EARTH

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

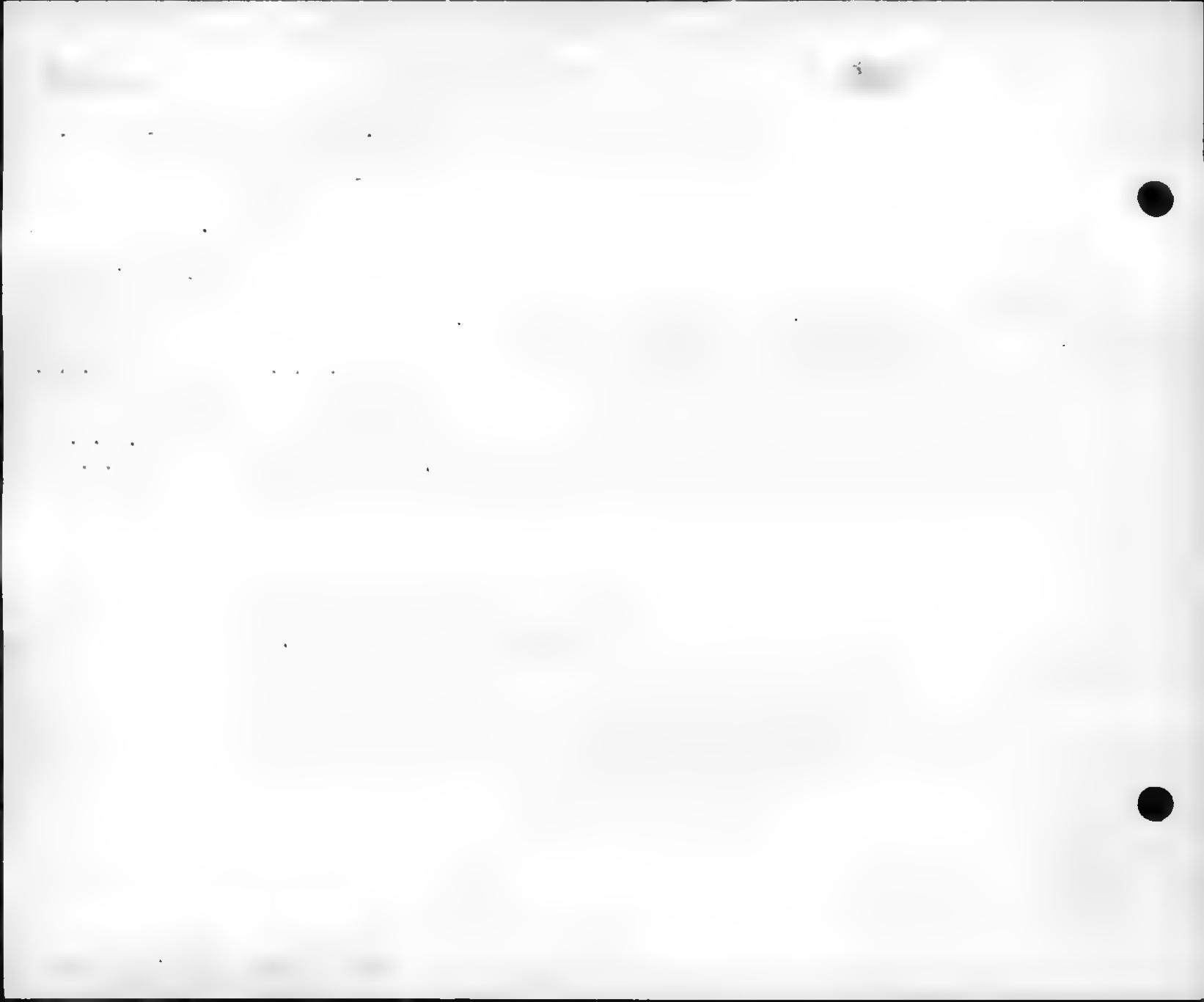
08666

08656

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

PLACE OF DEATH 0 COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 0 STATE <i>Md.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c LENGTH OF STAY IN 1b <i>17 days</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburbia</i>		d STREET ADDRESS <i>1510-Woodfield Rd.</i>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Ellen</i>	Middle <i>Farnally</i>	Last <i>Krebs</i>
4. DATE OF DEATH	Month <i>JUN.</i>	Day <i>10</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <i>Divorced</i>	8. NEVER MARRIED DIVORCED <i>Divorced</i>
9. AGE (In years lost birthday) <i>71 yrs</i>	10. DATE OF BIRTH <i>3/8/95</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	10b. KIND OF BUSINESS OR INDUSTRY	14. MOTHER'S MAIDEN NAME <i>Mary Delaney</i>	
13. FATHER'S NAME <i>Anthony Farnally</i>	15. ADDRESS <i>326-Benton St. N.W. Mary Farnally, Washington, D.C.</i>		
16. SOCIAL SECURITY NO <i>217-52-8227</i>		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myeloblastic Leukemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>as above</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>SC43</i>			
(b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Premature bilateral and generalized arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>May 10, 1966, to June 10, 1966, that (I) (we) last saw the deceased alive on June 10, 1966, and that death occurred at 6:00 P.M., from causes and on the date stated above.</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Jun 10 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <i>Not While of work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Arlington, Va.</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 1966, to <i>June 10, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 10, 1966</i> , and that death occurred at <i>6:00 P.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>George H. Mitchell</i>		22b. DATE SIGNED <i>June 10, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>GEORGE H. MITCHELL</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>June 14, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Cemetery</i>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>H. Don. DeVol 2222 Wiss. Ave NW</i>		25a. ADDRESS <i>2222 Wiss. Ave NW</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
25c. DATE <i>JUN 16 1966</i>			

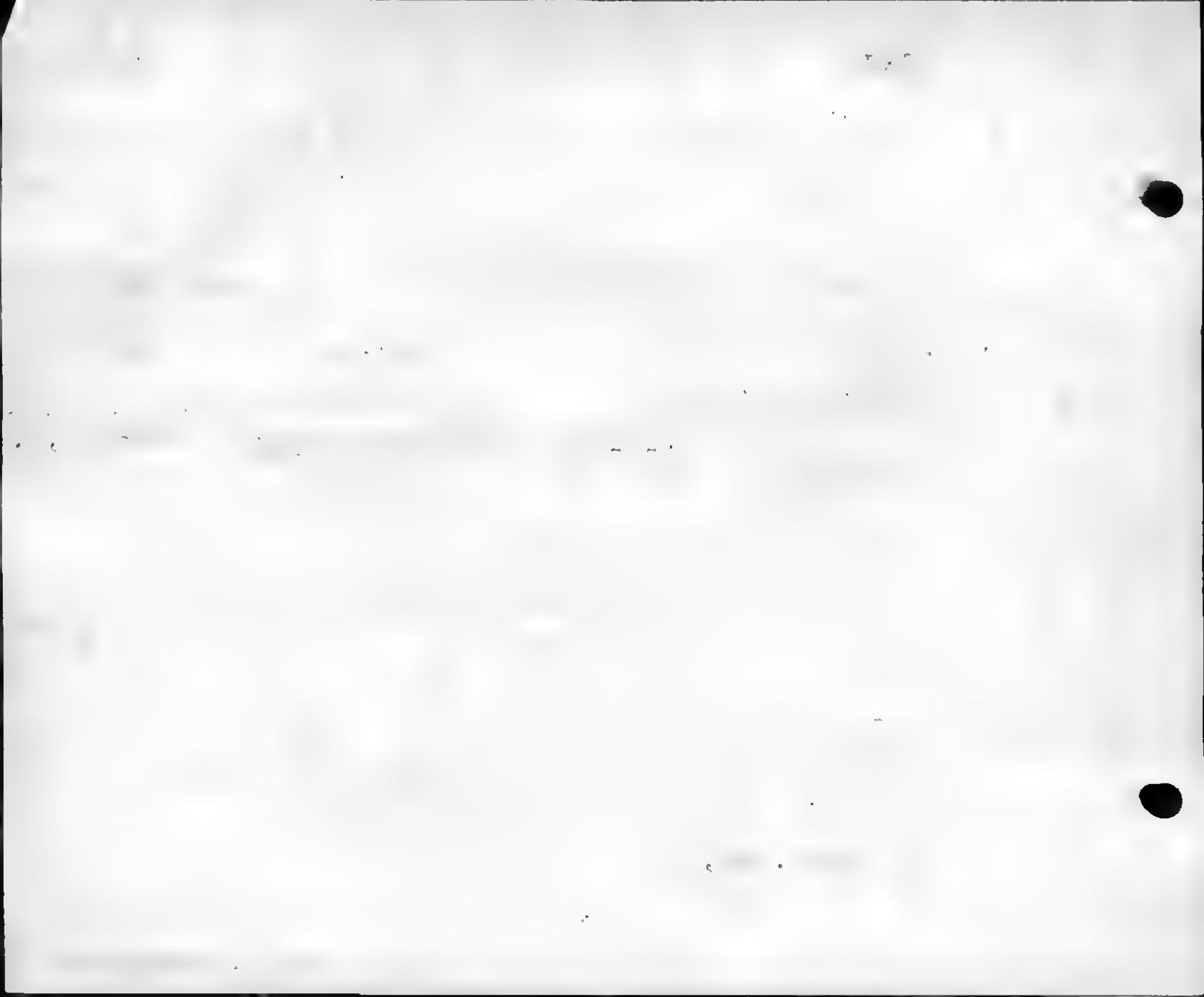


1 M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
Montgomery				Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1D 14 dn.									
Crown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 8828 Lanier Dr.									
Wide Water on C.R. Canal				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year				
John		Robert		Kunkel		June	4		1966				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
M.		W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/8/1926		39 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)					
US Army EM				U.S. Army				Pennsylvania					
12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME HENRY HERMAN KUNKEL (LIVING)													
14. MOTHER'S MAIDEN NAME AGNES CLARA DOERR (LIVING)													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO.				17. INFORMANT					
				195-18-3200				HENRY S KUNKEL/BROTHER/					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning (c)													
INTERVAL BETWEEN DEATH AND DEATH 3 mos.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swimming in Canal - dove in cold water.									
20c. TIME OF INJURY Month, Day, Year 6:45 a.m. 6/4 1966				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) Canal		20f. (City or town) Crown		(County) Mont. Md.		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John G. Ball													
EXAMINER'S NAME (Type) JOHN G. BALL, MD													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6-8-1966				23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATL				23d. LOCATION (City, town or county) FT MYER	
(State) VA													
24. FUNERAL DIRECTOR W.W. Chambers				25a. ADDRESS 3655 Ga Ave Silver Spring Md				25b. REC'D BY REGISTRAR JUN 8 1966				25c. REGISTRAR'S SIGNATURE Charles Judge	
DATE JUN 8 1966													



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

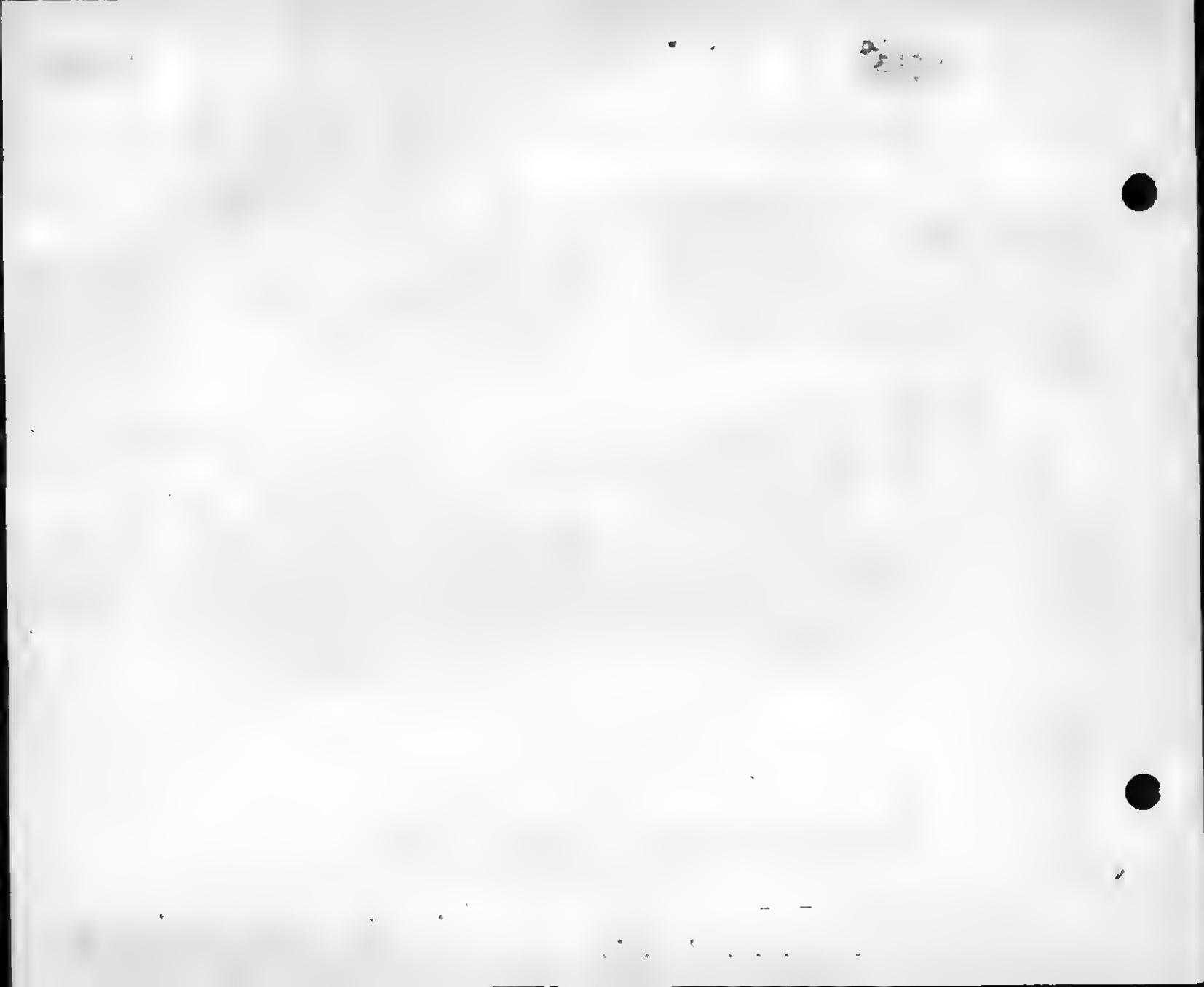
## CERTIFICATE OF DEATH

08658

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7202 LENHART DRIVE, MD</b>		d. STREET ADDRESS <b>7202 LENHART DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>LEON</b>	Middle <b>V.</b>	Last <b>LANGAN</b>
4. DATE OF DEATH <b>June 24 1966</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-1908</b>
9. AGE IN YEARS (last birthday) <b>57 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>LEON B. LANGAN</b>	14. MOTHER'S MAIDEN NAME <b>IRENE VERDIN</b>	Address <b>7202 LENHART DRIVE CHEVY CHASE, MD.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>YES WWII 1943-1945</b>	16. SOCIAL SECURITY NO. <b>499-07-0191</b>	17. INFORMANT <b>MARY G. LANGAN</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>June 24 1966</b> , that (I) (we) last saw the deceased alive on <b>6-22 1966</b> and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sanford J. Randall</b>	22b. DATE SIGNED <b>6-24-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>SANFORD J. RANDALL</b>	22d. ADDRESS <b>3636 16 St. N.W. DC</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-27-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington at 11 Com</b>	23d. LOCATION (City, town or county) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>	25a. RECORD BY REGISTRAR ADDRESS <b>5130 Wisc. Ave. N.W. Wash. DC.</b>	25b. REGISTRAR'S SIGNATURE DATE JUN 27 1966	<b>Charles Judge</b>



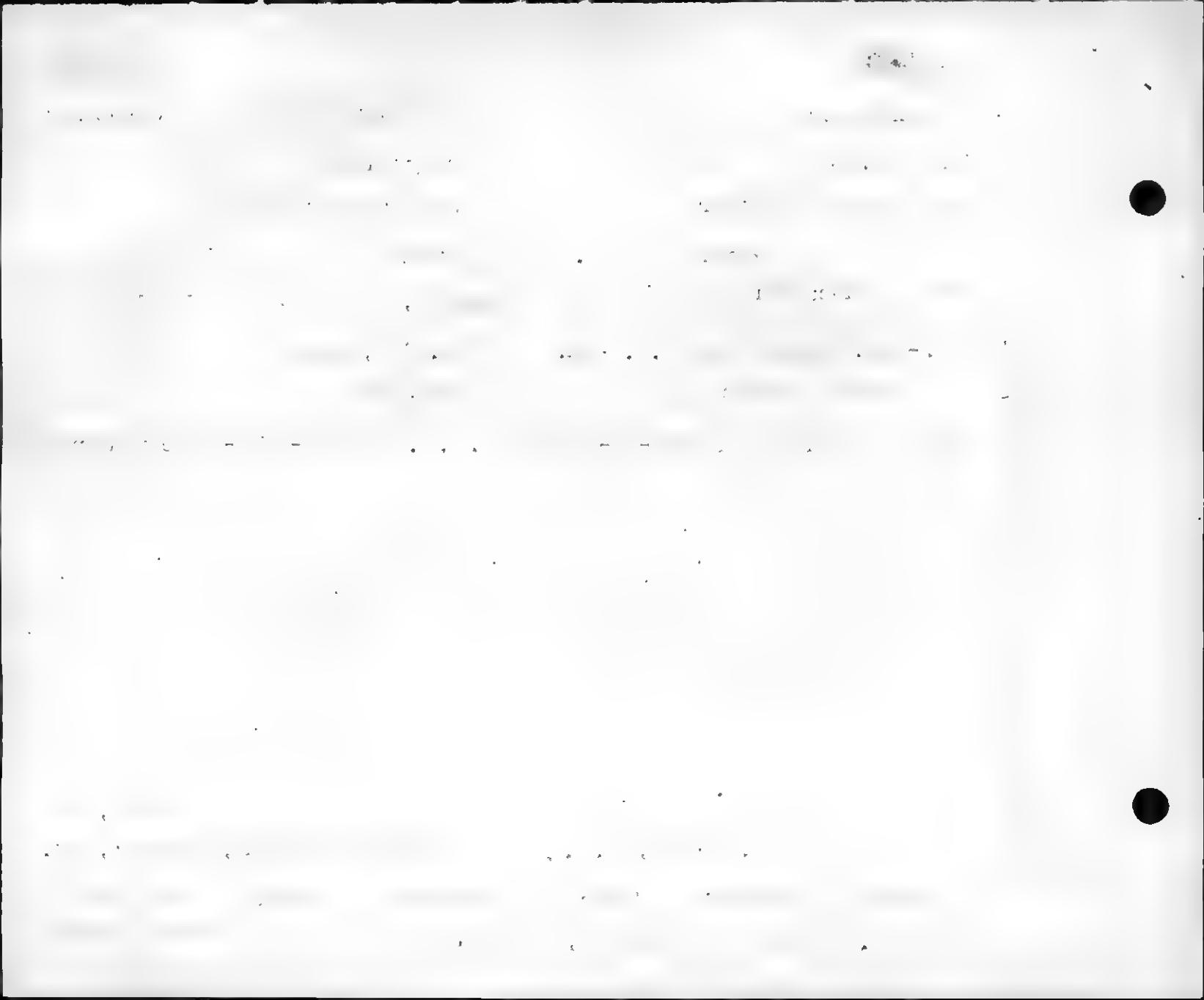
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER NOTIFIED AND APPROVED 6/21/1966

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> ?					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4740 Bradley Boulevard</b>					e. STREET ADDRESS <b>4740 Bradley Boulevard</b>				
3. NAME OF DECEASED (Type or print)		First <b>Loren</b>	Middle <b>H.</b>	Last <b>LAUGHLIN</b>	4. DATE OF DEATH <b>JUNE 21 1966</b>	Month <b>JUNE</b>	Day <b>21</b>	Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6, 1896</b>	9. AGE (in years last birthday) <b>69 yrs.</b>	10. IF UNDER 1 YEAR <b>10</b>	11. IF UNDER 24 HRS. <b>15</b>	12. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Atty. - Fed. Trade Comm U.S. Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Ayr, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Weldon Laughlin</b>		14. MOTHER'S MAIDEN NAME <b>Belle Hass</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>WWI &amp; WWII 505-38-8334</b>		17. INFORMANT <b>Mrs. L. H. Laughlin-Wife-Same as Item #2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysema</b>									
1810 OUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) OUE TO (c) <b>Carcinomatosis</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cancer of Urinary Bladder</b>									
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>6/20/66</b>		(County) (State)	
21. I certify that (I) (we) attended the deceased from <b>5/25</b> , 19 <b>66</b> , to <b>date 6/20/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>June 22, 1966</b>							
22a. SIGNATURE <b>Alex F. Castro, M. D.</b>		22d. ADDRESS <b>11125 Rockville Pike, Rockville, Md.</b>							
22c. PHYSICIAN'S NAME (Type)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6/22/1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>			
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. ADDRESS <b>Bethesda, Maryland</b>		25b. REC'D BY REGISTRAR <b>JUN 23 1966</b>		25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
VR A15 (4) 20M 1/65									

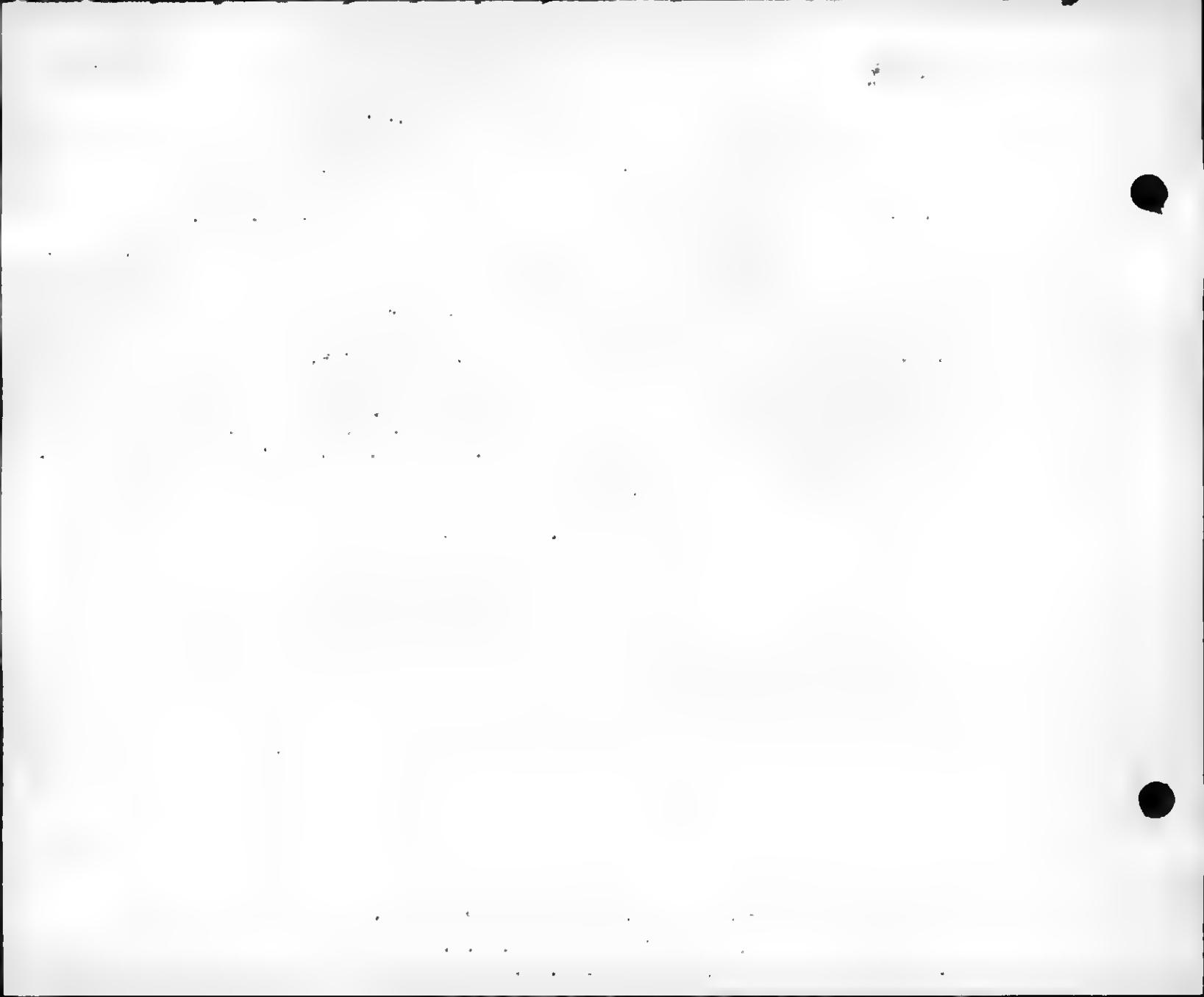


1  
FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.A. Page 5 may be retained for your files.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						1186660					
<p>1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) DOA</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda</p> <p>d. STREET ADDRESS 7563 Spring Lake Dr. Apt. C2</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.				
male		Cauc	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 13, 1900	66 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Coast Guard				10b. KIND OF BUSINESS OR INDUSTRY Government				11. BIRTHPLACE (State or foreign country) Philadelphia, Penn			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Leamy						14. MOTHER'S MAIDEN NAME Laura M. Weckerly					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) yes 1924-1960			16. SOCIAL SECURITY NO. 17. INFORMANT 278 36 2721 Apt. C2, Bethesda, Maryland			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) Coronary occlusion. INTERVAL BETWEEN ONSET AND DEATH: Recent. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cardio-Vascular Disease - Recent years.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Boll</i>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 25 June 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-28-1966		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR		ADDRESS Joseph Gawler & Sons, 5130 Wisconsin Ave. N.W. Joseph Gawler & Sons Washington, D.C. 5730 Wisconsin Ave.		25a. REC'D BY REGISTRAR DATE JUN 30 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A1SME (5) 5M 1/65											



CASE CLEARED BY

1 CORONER

X 3671

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film 578 7/8/66 mh

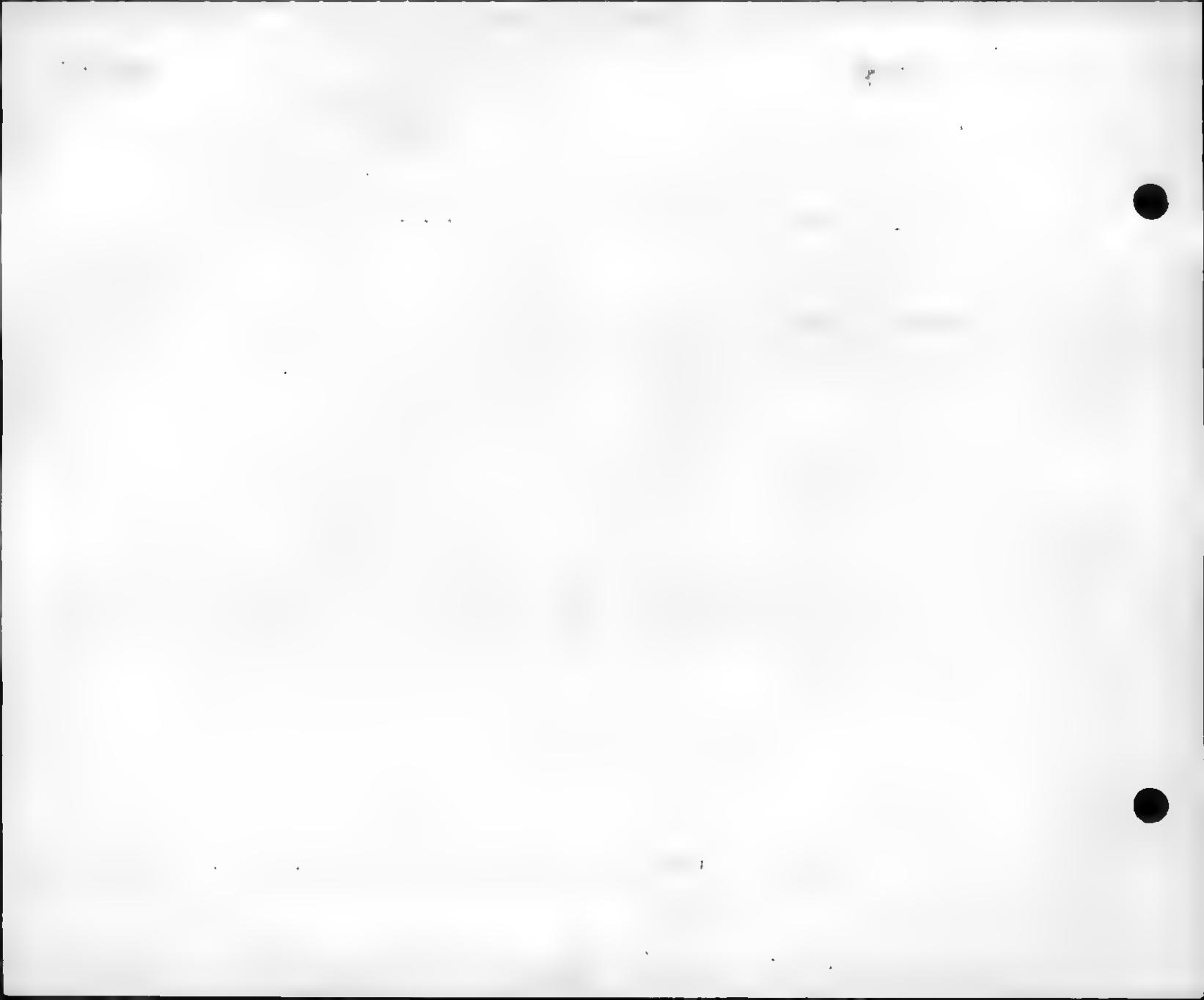
## CERTIFICATE OF DEATH

08661

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		b. COUNTY <b>Stevensville</b>	
c. LENGTH OF STAY IN 1b <b>14 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Nursing Home</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		d. STREET ADDRESS <b>R.F.D. #1, Box 52A</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ADA</b>	Middle <b>LEWELLEN</b>	Last
4. DATE OF DEATH	Month <b>6</b>	Day <b>30</b>	Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/7/1883</b>
9. AGE (In years last birthday) <b>82 3 yrs</b>		10. IF UNDER 1 YEAR Months <b>82</b>	11. IF UNDER 24 HRS Days <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Fayette Co., Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Andrew Robbins</b>		14. MOTHER'S MAIDEN NAME <b>Susan Zimmerman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John Dull</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4330</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arteriosclerotic cardiovascular disease</b>	
		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-26-66</b> to <b>6-30-66</b> , that (I) (we) last saw the deceased alive on <b>5-26-66</b> , and that death occurred at <b>3pm</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Morrill C. Quinnam Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Morrill C. Quinnam Jr.</b>		22d. ADDRESS <b>2731 Conn. Ave., N. W., Washington, DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 2, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>UNION CEMETERY</b>
24. FUNERAL DIRECTOR <b>J. Arthur Walters</b>		ADDRESS <b>254 Carroll St. N.W. Washington, D.C.</b>	25a. REC'D BY REGISTRAR DATE JUL 5 1966
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

014662

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

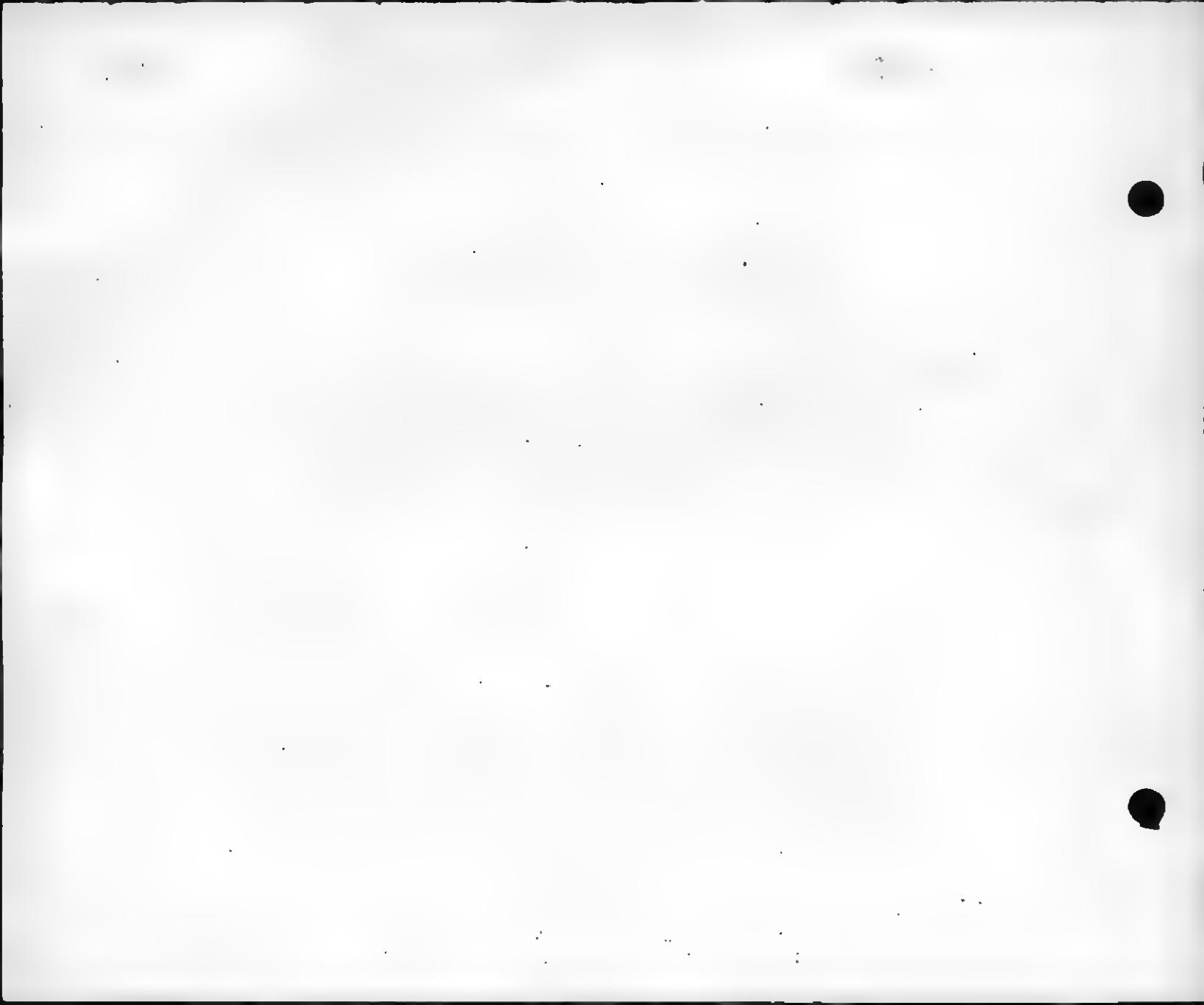
2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.

Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN b. <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lori</b> First <b>Anne</b> Middle <b>Light</b>		4. DATE OF DEATH <b>June 21</b> Month Day Year <b>1966</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <b>June 20, 1966</b> 9. AGE (In years last birthday) yrs <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Bethesda, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Edgar Light</b>		14. MOTHER'S MAIDEN NAME <b>Linda Anne Mowatt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Mr. William E. Light, 7459A 80th Ave./</b> Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atelectasis bilateral, secondary to prematurity</b> <b>1625</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>445 F M</b> (County) <b>Arlington</b> (State) <b>Virginia</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 20</b> , 1966, to <b>June 21</b> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 21</b> , 1966, and that death occurred at <b>445 F M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Gordon W. Mella</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>June 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon W. Mella, M. D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Check)		23b. DATE THEREOF <b>June 24, 1966</b> 23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b> 23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey Funeral Home</b> ADDRESS <i>Other Costs</i> <b>8434 Georgia Ave., Silver Spring, Maryland</b>		25a. REC'D. BY REGISTRAR <b>JUN 24 1966</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	







## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08674

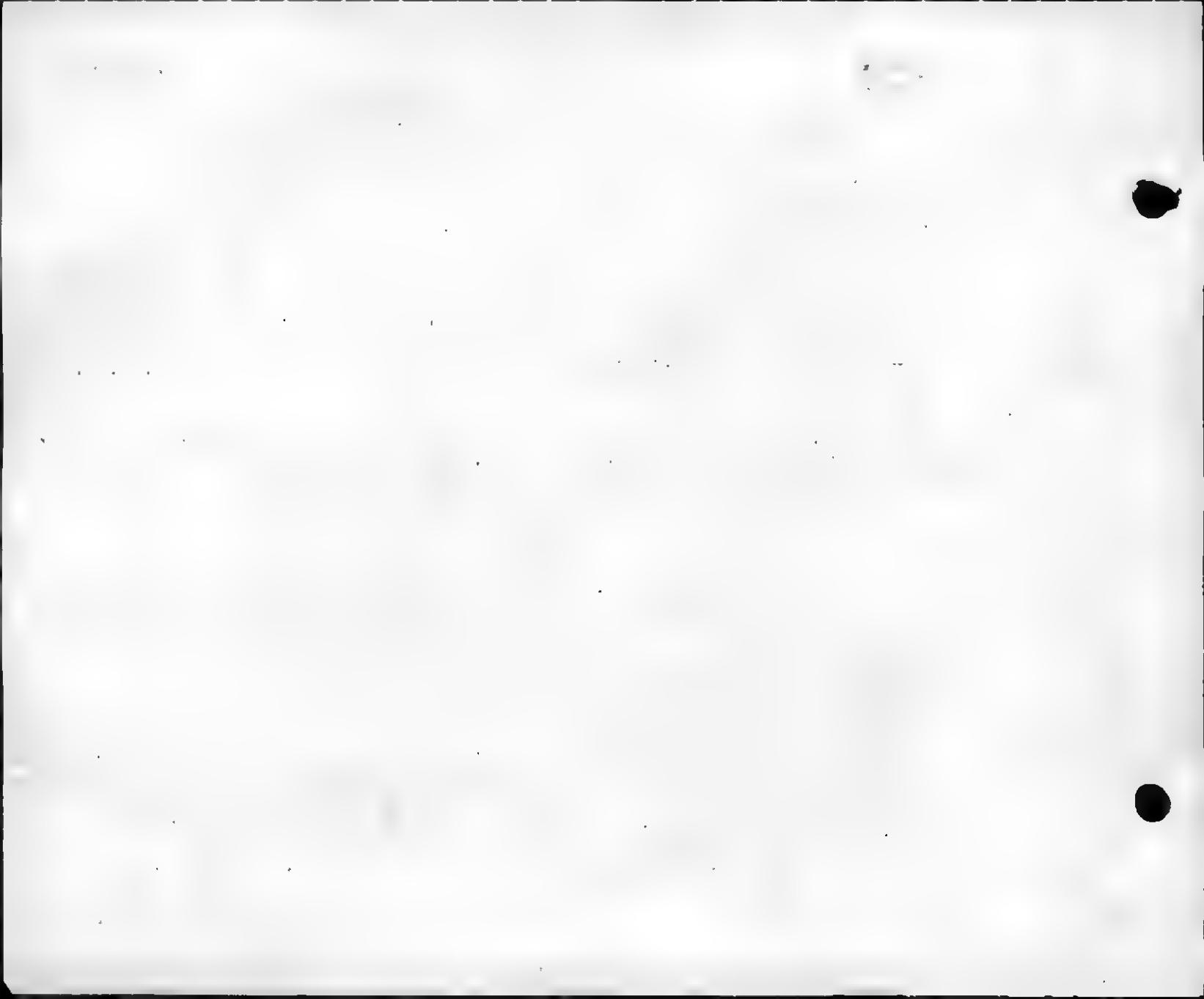
## CERTIFICATE OF DEATH

188664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE New York b. COUNTY Queens ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fairland Nursing Home		d. STREET ADDRESS 123 - 60 83rd Avenue				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First LOUIS	Middle	4. DATE OF DEATH Month June Day 24 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH June 2, 1886		9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Painting				
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Sam Litoff		14. MOTHER'S MAIDEN NAME Rebecca ? ? ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Not known		16. SOCIAL SECURITY NO 578-12-4644 17. INFORMANT Mrs. Lillian Rothblat Address 201 E. 28th St. New York City				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (i)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) Longstanding Decompensation DUE TO (c) Arteriosclerosis + old age		19. INTERVAL BETWEEN ONSET AND DEATH Acute heart failure years gears years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1966</u> to <u>June 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1966</u> , and that death occurred at <u>11:22 A.M.</u> from causes and on the date stated above.						
22a. SIGNATURE Richard P. Delaney		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6-24-66	
22c. PHYSICIAN'S NAME (Type) Richard P. Delaney		22d. ADDRESS 4323 Harvard Street Silver Spring, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-26-66	23c. NAME OF CEMETERY OR CREMATORIAL Nat'l Memorial Park	23d. LOCATION (City or Town) Falls Church	(County) Va.	(State)
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 9th St., N. W.		25a. REC'D BY REGISTRAR DATE JUN 27 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

08673

08665

**CERTIFICATE OF DEATH**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.																			
Page 4 may be retained by the hospital or attending physician.																			
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.																			
MEDICAL CERTIFICATION		1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE														
		Maryland			U.S. <i>Washington</i>														
B. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b ??			c. LENGTH OF STAY IN 1b ??											
		Silver Spring			Washington			Washington											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
		Holy Cross			3637 Harrison St.														
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year											
		Anders	R.	Lofstrand	May 23	1886	80	1	3										
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 18 yrs	IF UNDER 24 HRS												
		M	W	WIDOWED <input type="checkbox"/> DIVDRCD <input type="checkbox"/>	May 23, 1886	80 yrs	Months	Days	Hours	Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?											
		Manufacturer			heavy duty			Stockholm, Sweden			USA								
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME																	
		Anders Lofstrand			Elizabeth Unknown														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN DEATH AND AUTOPSY								
		577-38-2126			1915 Rookwood Rd. - Silver Spring, Md.			Edward F. Jurnell / son-in-law											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b)			DUE TO (c)			acute myocardial infarction Secondary arteriosclerosis		INTERVAL BETWEEN DEATH AND AUTOPSY									
												4201							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)			DUE TO (c)			acute myocardial infarction Secondary arteriosclerosis		INTERVAL BETWEEN DEATH AND AUTOPSY									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
		19																	
21. I certify that (I) (this hospital) attended the deceased from May 19, 65 to June 26, 1966, that (I) (we) last saw the deceased alive on June 22, 1966, and that death occurred at <i>10th</i> M., from the causes and on the date stated above.		22a. SIGNATURE			22b. DATE SIGNED														
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
											Robert A. Pumphrey			Bethesda, Maryland					
26. DATE		27. SIGNATURE																	
					JUN 29 1966														

1. *Thlaspi* *luteum*

2. *Thlaspi*

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08676

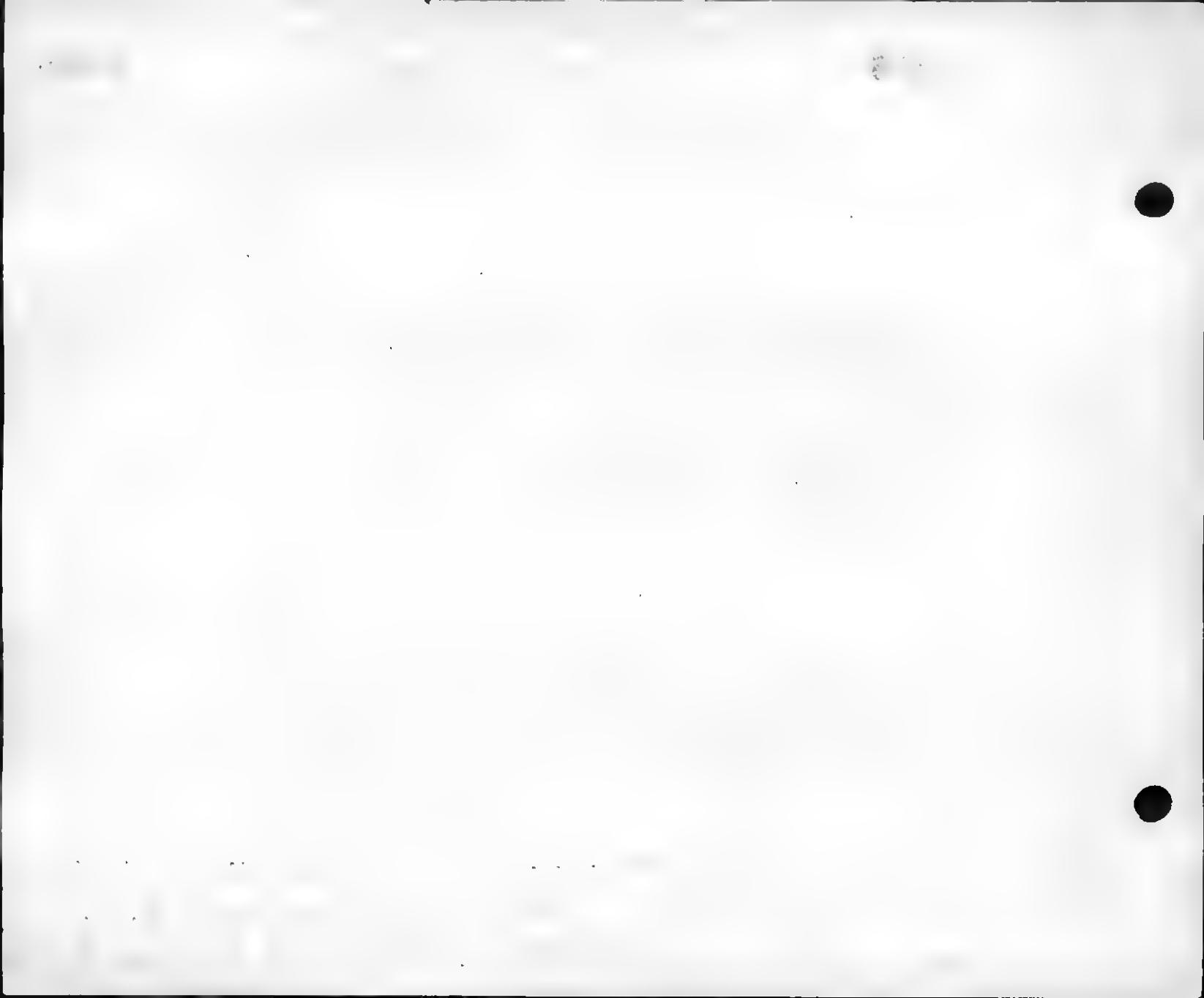
## CERTIFICATE OF DEATH

08666

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits Write RURAL and give nearest town)		c. LENGTH OF STAY IN lb D. O. A.	
Takoma Park		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 730 Thayer Ave	
Washington San + Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Female		Florence	(Jones)
3. NAME OF DECEASED (Type or print)		Last	4. DATE OF DEATH 6 - 19 - 1966
5. SEX		6. COLOR OR RACE	7. MARRIED NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		White	8. DATE OF BIRTH 2-26-1899
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired)		9. AGE (In years last birthday) 67 yrs	
Sales lady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13. FATHER'S NAME		11. BIRTHPLACE (Country & State or foreign country) Maryland	
Edward Jones		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 220-07-3477	
No None		17. INFORMANT Mrs Ruth Oates 728 Thayer Ave. Silver Spring	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Address INTERVAL BETWEEN ONSET AND DEATH acute asthma	
acute asthma		15 yrs.	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		15 yrs.	
(b) DUE TO Ch. Asthma		15 yrs.	
(c) DUE TO Emphysema		15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-10-1966 to 6-20-1966, that (I) (we) last saw the deceased alive on 6-9-1966, and that death occurred at 6-20-1966 M, from causes and on the date stated above.			
22a. SIGNATURE Francis X. Richardson		22b. DATE SIGNED 6/20/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 11412 Viers Mill Rd., Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 22, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.	
24. FUNERAL DIRECTOR Jack Thomas 8434 Georgia Avenue Warren E. Purphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR JUN 22 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02873

## CERTIFICATE OF DEATH

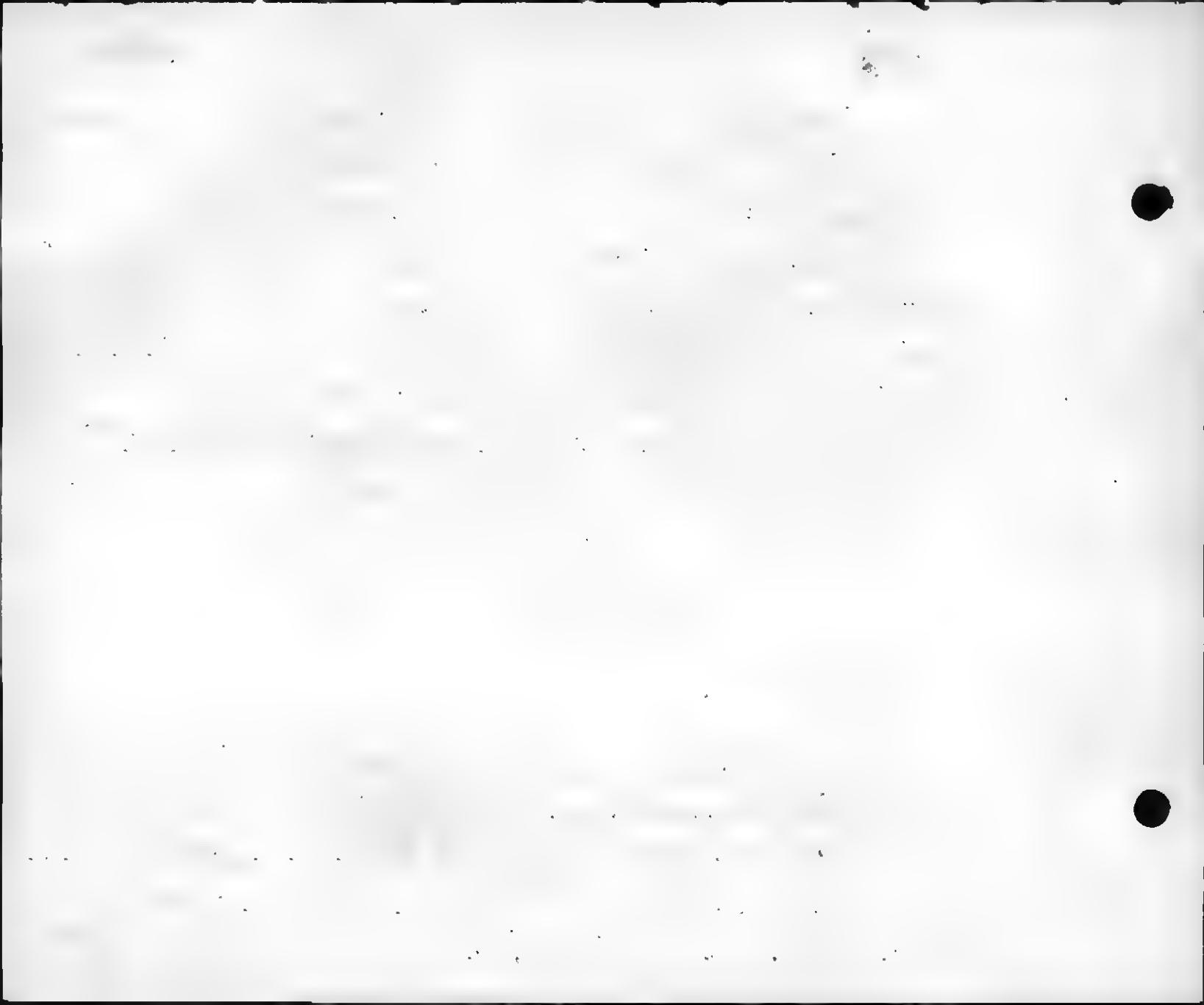
08667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the ~~final~~ certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 11443 Lockwood Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
Angelina Grace Marinaccio June 22 1966		5. SEX	
Female White		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIOOWEO <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) IF UNDERR 1 YEAR IF UNDERR 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Aiello		14. MOTHER'S MAIDEN NAME Josephine Perricone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No None		16. SOCIAL SECURITY NO. 579-22-1923	
17. INFORMANT Mrs. Robert Mazzolini		Address 1403 Sheppi Lane Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		2 DAYS	
201X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c)		4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 6/20, 1966, to 6/22, 1966, that (I) (we) last saw the deceased alive on 6/21, 1966, and that death occurred at 12 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Lawrence J. Thomas		22b. DATE SIGNED 6/22/66	
22c. PHYSICIAN'S NAME (Type) Lawrence J. Thomas		22d. ADDRESS 1712 Eye St., N. W., Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		23d. LOCATION (City, town or county) Arlington, Virginia (State)	
24. FUNERAL DIRECTOR John B. Thomas Warner L. Purphrey, Inc.		ADDRESS 8434 Georgia Avenue	
25a. REC'D BY REGISTRAR JUN 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

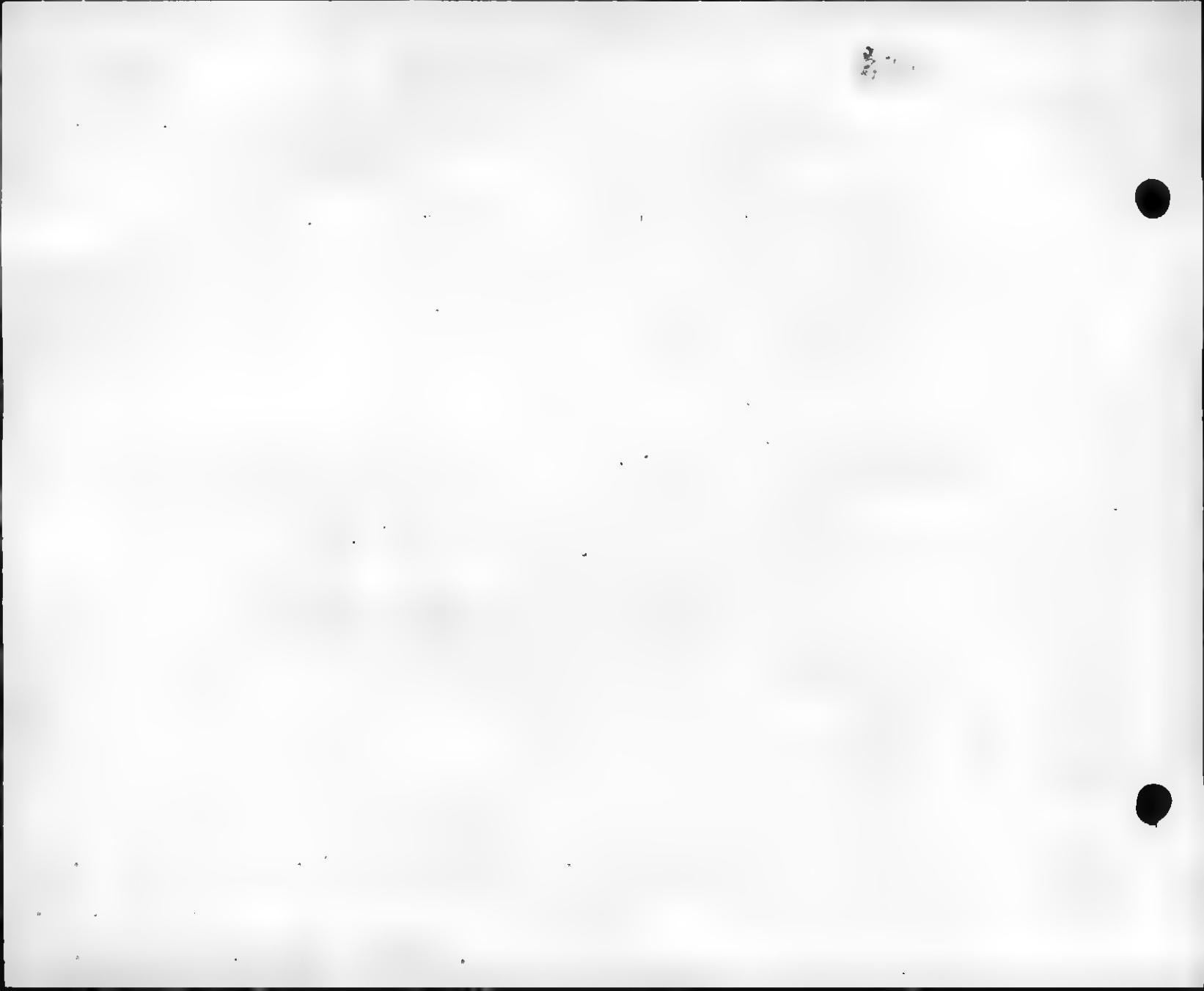
## CERTIFICATE OF DEATH

08668

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if instit. an Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN lb <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		e. STREET ADDRESS <b>615 STONESTREET, LINCOLN PARK</b>	
3. NAME OF DECEASED (Type or print) <b>EDNA</b>		First <b>LOUISE</b>	Middle <b>MARTIN</b>
4. DATE OF DEATH <b>6</b>	Month <b>4</b>	Day <b>1966</b>	Year
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>3-19-16</b>		9. AGE (In years last birthday) <b>50 yrs</b>	
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES BRUNNER</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES KNICKENS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-14-8727</b>	
17. INFORMANT <b>MEDICAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pancreatitis with peritonitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5310</b> (b) <b>Loewert's (Nutritional) Cirrhosis</b> <b>Years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Montgomery</b> (County) <b>Maryland</b> (State) <b>MD</b>		21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>Montgomery</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>Frederick Maonane</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM C. MILLER, M. D.</b>		22d. ADDRESS <b>7 BROOKS AVE., GAITHERSBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/8/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Lincoln Park</b>
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Mo.</b>	25a. REC'D BY REGISTRAR <b>JUN 9 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

22679

## CERTIFICATE OF DEATH

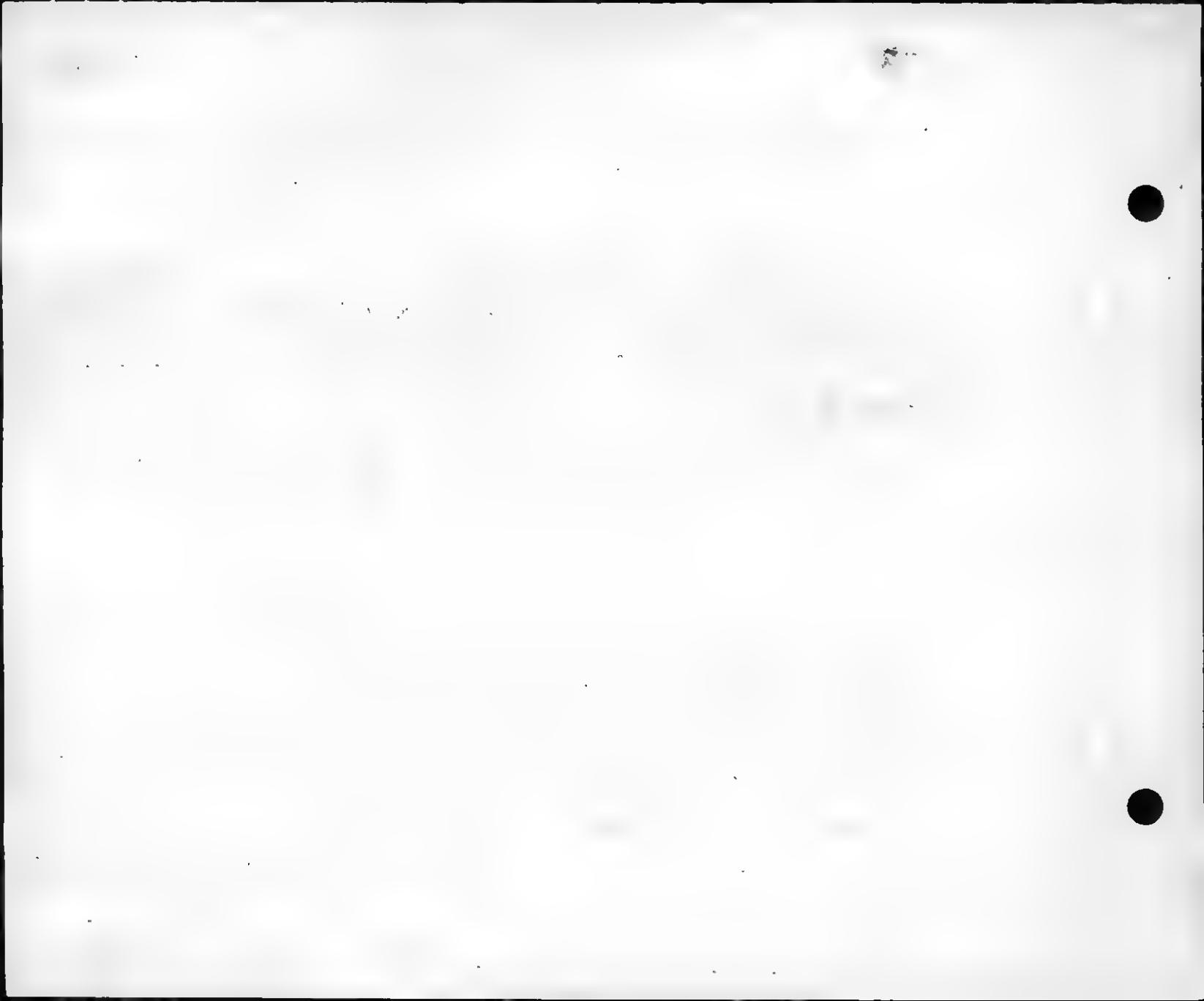
118669

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>2305 EVANS DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>YAYEKO</b>		First <b>Y</b>	Middle <b>A</b>
4. DATE OF DEATH Last <b>6 4 1966</b>		Month <b>6</b>	Day <b>4</b>
5. SEX <b>F</b>		6. COLOR OR RACE <b>ORIENTAL</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <b>7/13/1900</b>		9. AGE (in years last birthday) <b>65 yrs.</b>	10. FUNDER 1 YEAR Months <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>JAPAN</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Scott Matsumoto</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>219-54-9686</b>		17. INFORMANT <b>Scott Matsumoto</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <b>(c)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1966</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Metastatic Carcinoma Carcinoma Head of Pancreas</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <b>While not working at work</b>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <b>19</b> p.m.		20d. INJURY OCCURRED <b>While not working at work</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9911 Georgia Ave Silver Spring Md.</b>
20f. (City or town) <b>MERTON L. WHITE</b>		(County) <b>M.D.</b>	(State) <b>MD.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>4 June 1966</b> , that (I) (we) last saw the deceased alive on <b>4 June 1966</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Merton L. White</b>		22b. DATE SIGNED <b>4 June 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Merton L. White</b>		22d. ADDRESS <b>9911 Georgia Ave Silver Spring Md.</b>	22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>JUNE 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>
24. FUNERAL DIRECTOR <b>Elton Carter</b>		24b. ADDRESS <b>8434 Georgia Avenue Warren E. Humphrey, Inc. Silver Spring, Md.</b>	25a. REC'D BY REGISTRAR <b>JUN 8 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08670

1		M		08670											
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.													
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 44 Days		b. COUNTY											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) John		First Middle Roosevelt		Last Marion		4. DATE OF DEATH June 21 1966		Month Day Year							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 29 October 1901		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Nat L. Marion		14. MOTHER'S MAIDEN NAME Martha Hancock													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address Not available		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease, Aortic / insufficiency DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
						INTERVAL BETWEEN ONSET AND DEATH minutes									
						stenosis and 28 years									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 May 1966, to 21 June 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 June 1966, and that death occurred at 1:20 P.M. from the causes and on the date stated above.		22a. SIGNATURE Douglas M. Behrendt		22b. DATE SIGNED P 21 June 1966											
22c. PHYSICIAN'S NAME (Type) Douglas M. Behrendt, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF June 21, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Double Creek		23d. LOCATION (City, town or county) Surry Co., North Carolina									
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS 7557 Wisconsin Ave Bethesda, Md.		25a. REC'D BY REGISTRAR JUN 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge									



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

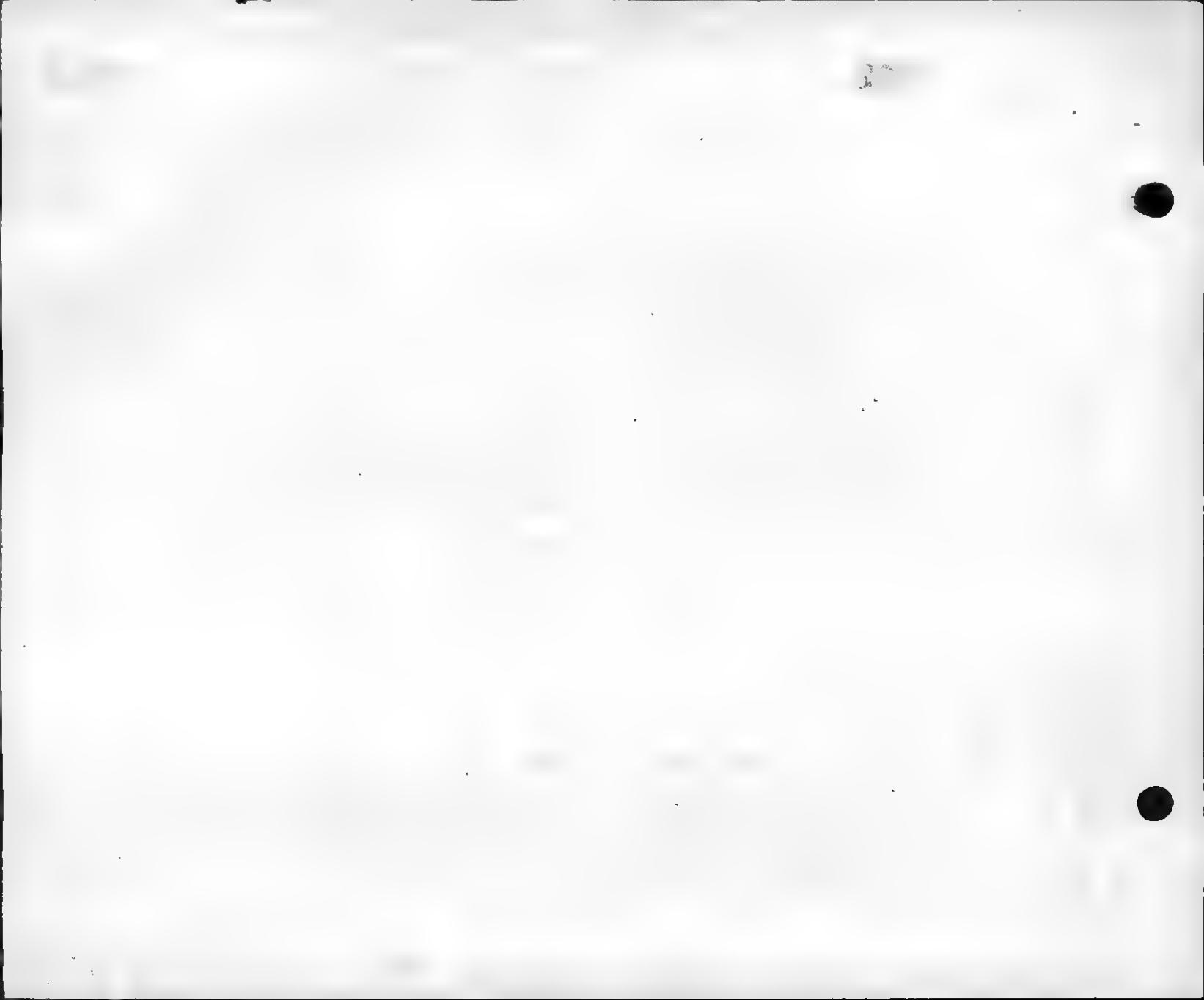
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3, should be detached for use as the burial-trust permit when please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

98681

CERTIFICATE OF DEATH

118671

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Resmore Hospital &amp; San.</b>		d. STREET ADDRESS <b>5522 Southwick St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NANCY J. McCracken.</b>		First	Middle
4. DATE OF DEATH Month <b>6</b> Day <b>2</b> Year <b>1966</b>		Last	Month
5. SEX <b>Female</b> COLOR OR RACE <b>white</b>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>3-24-1890</b> 9. AGE (In years lost birthday) <b>76 yrs</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>David</b> <del>John</del> <b>Bee Low</b>		14. MOTHER'S MAIDEN NAME <b>Hanna VanHoosier</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-52-6743</b> 17. INFORMANT <b>Sarah J. Henderson-Henry #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>332X</b> <b>Cardiovascular collapse</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <b>200 hours</b></span> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cerebro-vascular thrombosis</b> <span style="float: right;">sev. week</span>		DUE TO (b) <b>Generalized arteriosclerosis</b> <span style="float: right;">many yrs.</span>	
DUE TO (c) <b>Urinary Diabetes Nephritis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b> (County) <b>Maryland</b> (State)	
21. I certify that (I) (This hospital) attended the deceased from <b>May</b> , 1963, to <b>June 2</b> , 1966, that (I) (we) last saw the deceased alive on <b>May 26 1966</b> , and that death occurred at <b>5:30 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>George H. Mitchell</b>			
22c. PHYSICIAN'S NAME (Type) <b>George H. Mitchell</b>		22b. DATE SIGNED <b>June 2, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/6/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn</b>		23d. LOCATION (City or Town) <b>Rockville</b> (County) <b>Maryland</b> (State)	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1331 Rockville Rd.</b>	
25a. REC'D BY REGISTRAR <b>JUN 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1 M  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08682

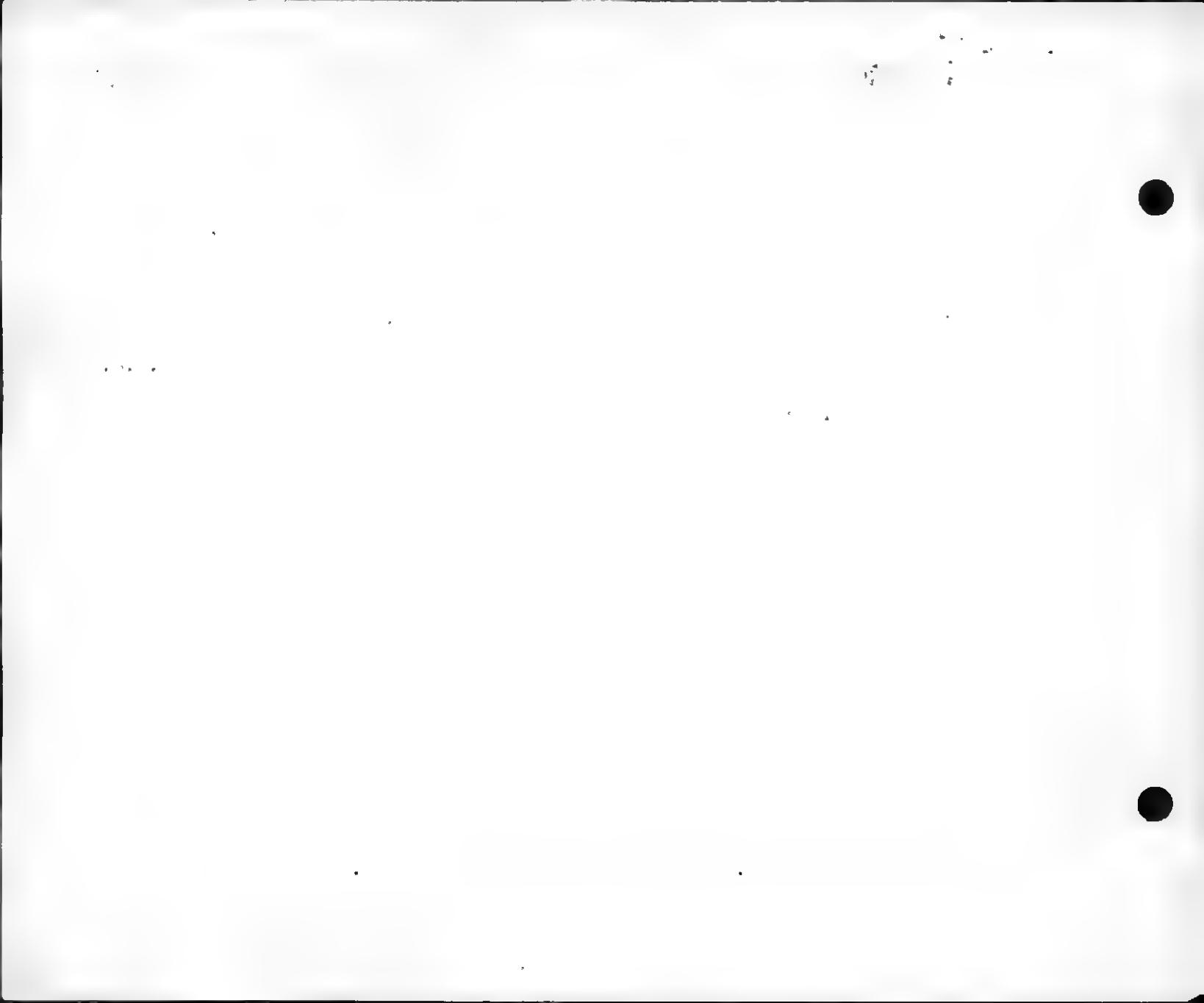
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08672

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN 1b <b>DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>TEXAS</b>		b. COUNTY <b>DALLAS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5927 HOLLAND ROAD</b>		c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>DALLAS</b>		d. STREET ADDRESS <b>7081 VILLAGE STAR APT. C</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CECIL</b>		First <b>GEORGE</b>		Middle <b>McGEE</b>		4. DATE OF DEATH <b>JUNE 28 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 18, 1901</b>		9. AGE (In years past birthday) <b>65 yrs</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESSMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POLLOCKPAPER&amp; BOX</b>		11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE W. McGEE</b>		14. MOTHER'S MAIDEN NAME <b>KATIE HALL</b>		15. ADDRESS					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>WILLIE McGEE WIFE SAME</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) DUE TO stating the underlying cause first (c) DUE TO stating the underlying cause first		19. INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Coronary Insufficiency Acute.</b> <b>Cardio-Vascular Disease.</b> <b>Years</b>					
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>John G. Ball</b>		23. ACTUAL SIGNATURE <b>John G. Ball</b>		24. EXAMINER'S NAME (Type) <b>John G. Ball 7936 1/2d Georgetown Street, Rockville, Maryland</b>		25. DATE REC'D BY REG STAR <b>JUN 30 1966</b>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/2/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Laurel Oaks</b>		23d. LOCATION (City or Town) (County) (State) <b>Mesquite Texas</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home Rockville, Maryland</b>		25a. ADDRESS <b>1330 Rockville Pike</b>		25b. REC'D BY REG STAR <b>JUN 30 1966</b>					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

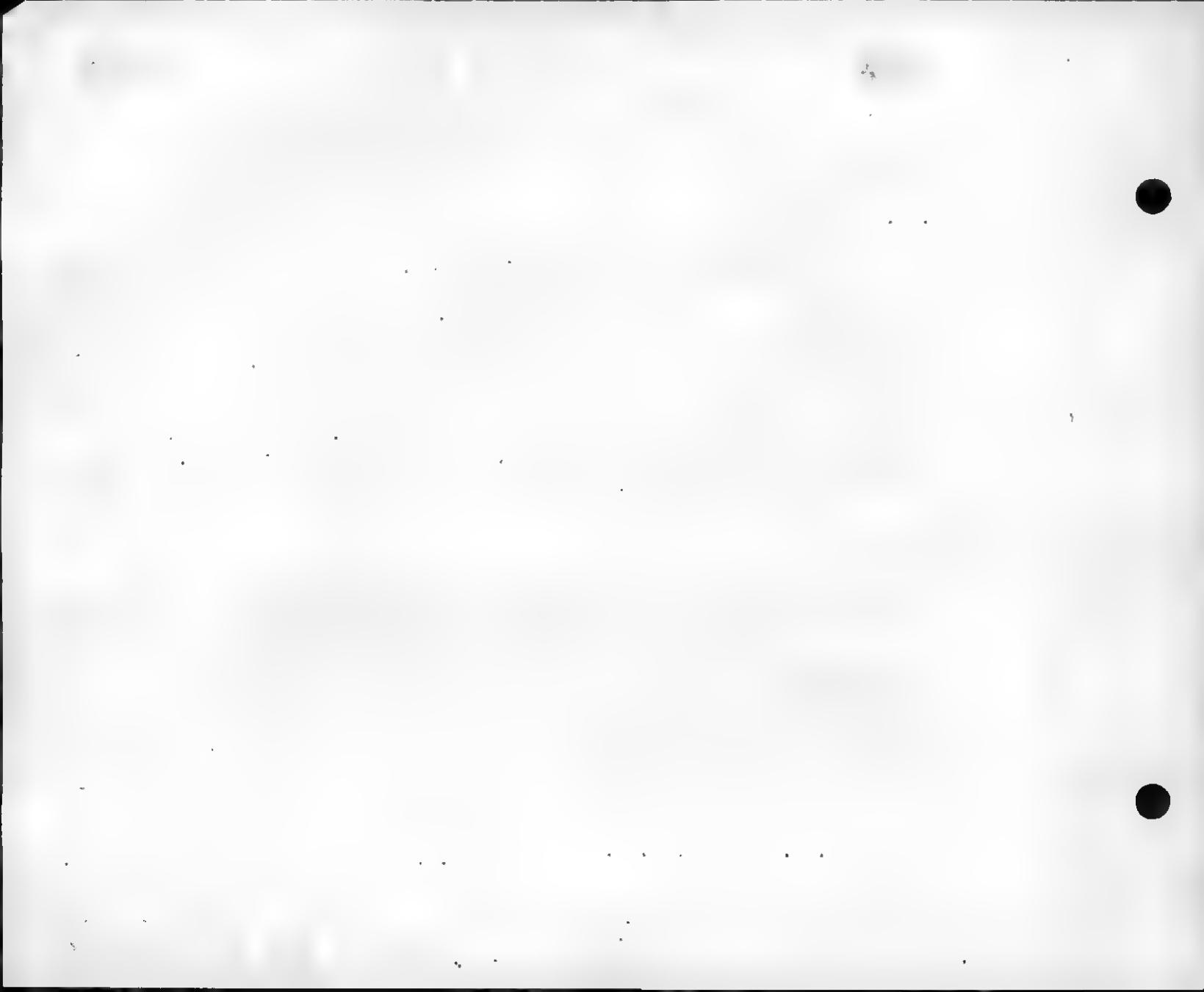
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

38683 08673

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH: a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>			d. STREET ADDRESS <b>11606 Joseph Mill Road</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Douglas Arthur McGRAW Jr.</b>	First	Middle	Lost	4. DATE OF DEATH <b>June 2</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1964</b>	9. AGE (In years last birthday) <b>1 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State or foreign country) <b>Silver Spring, Md.</b>	
13. FATHER'S NAME <b>Douglas Arthur McGraw</b>			14. MOTHER'S MAIDEN NAME <b>Doris Browne</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mill Rd., Wheaton, Md.</b> Address <b>Mr. Douglas Arthur McGraw, Sr. 11606 Joseph/</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH 491X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>1150 M.</b> (County) <b>Prince Georges Co.</b> (State) <b>Md.</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 1, 1966</b> , to <b>June 2, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 2, 1966</b> , and that death occurred at <b>1150 M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>R. F. Swanger, M.D.</b>			22b. DATE SIGNED <b>3 June 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>R. F. Swanger, M. D.</b>			22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 6, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>
24. FUNERAL DIRECTOR <b>W. E. Pumphrey Funeral Home, 8434 George Ave.,</b>		25a. ADDRESS <b>Silver Spring, Md.</b>		25b. RECD. BY REGISTRAR <b>JUN 8 1966</b>	25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 20 M 1/66					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

08684

## CERTIFICATE OF DEATH

118674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 141 Lea Court	
3. NAME OF DECEASED (Type or print) First Bert Middle Arthur Last McLean		4. DATE OF DEATH Month June Day 15 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
9. DATE OF BIRTH April 9, 1916		9. AGE (In years last birthday) 50 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY F.H.A.	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur A. McLean		14. MOTHER'S MAIDEN NAME Helen Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service yes 1939-1960		16. SOCIAL SECURITY NO. 497-01-1709	
17. INFORMANT Church Mrs. Mary C. McLean, 141 Lea Court, Falls		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gq Carcinoma of the lung DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (X) (this hospital) attended the deceased from June 14, 1966, to June 15, 1966 that (X) (we) last saw the deceased alive on June 15, 1966, and that death occurred at 105PM, from causes and on the date stated above.			
22a. SIGNATURE Joseph T. Mullen		22b. DATE SIGNED 16 June 1966	
22c. PHYSICIAN'S NAME (Type) Joseph T. Mullen, M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, Bur. REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/66	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Falls Church Funeral Home, 1102 West Broad St. Falls Church, Virginia		25a. REC'D BY REGISTRAR DATE JUN 20 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08685

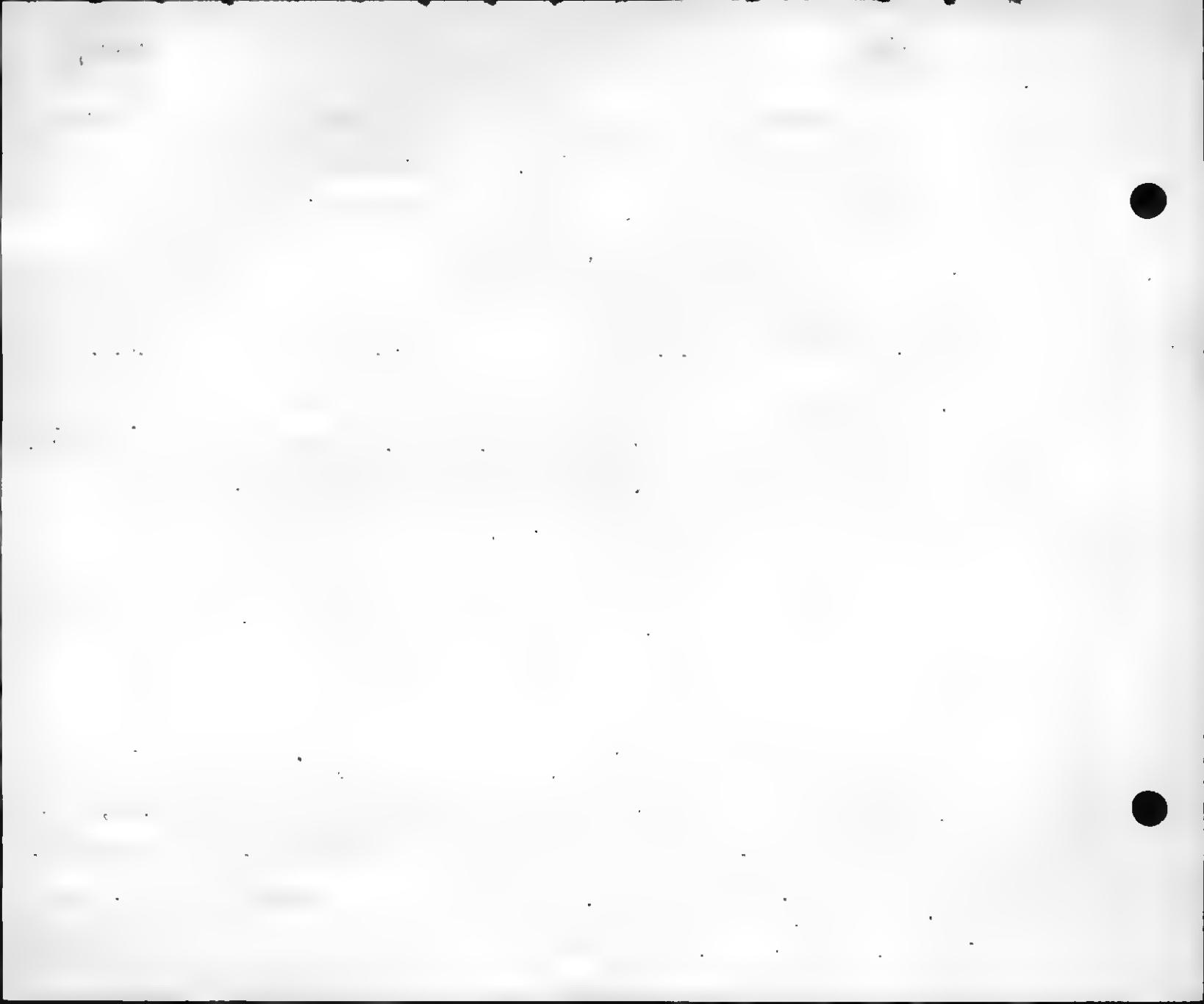
08675

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 1 1/2 years		d. STREET ADDRESS 1809 Brisbane Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1809 Brisbane Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anne Florence McPherson		4. DATE OF DEATH June 25 1966	Month Day Year
First Middle Last		5. SEX Fe	6. COLOR OR RACE W
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1893	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Secretary		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Waters		14. MOTHER'S MAIDEN NAME Nancy Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 245-14-4488	
17. INFORMANT Mrs. Mary M. Rhoades, 1809 Brisbane Street		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident this am.		INTERVAL BETWEEN ONSET AND DEATH 2+ years	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		Hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Right sided hemiplegia in May 1964			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1965 to June 25 1966, that (I) (we) last saw the deceased alive on June 8 1966, and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John N. Andrews		22d. DATE SIGNED June 25, 1966	
22c. PHYSICIAN'S NAME (Type) John N. Andrews		22d. ADDRESS 9601 Colesville Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Pisgah View Cemetery		23d. LOCATION (City, town or county) (State) Lander, North Carolina	
24. FUNERAL DIRECTOR John B. Holmes 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR JUN 28 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

22686

## CERTIFICATE OF DEATH

08676

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Chevy Chase

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

4131 Leland Street

3. NAME OF  
DECEASED  
(Type or print)First  
NaomiMiddle  
NelsonLast  
McWilliams4. DATE  
OF  
DEATH  
JuneMonth  
12  
Day  
19  
Year  
66

## 5. SEX

female

## 6. COLOR OR RACE

white

7. MARRIED  
WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

June 28-1898

9. AGE (In years  
last birthday)

67

yrs.

## 10. IF UNDER 1 YEAR

Months

Days

## 11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (County &amp; State, or foreign country)

West Virginia

## 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME

unobtainable

## 14. MOTHER'S MAIDEN NAME

Margaret Bramlett

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  NO

## 16. SOCIAL SECURITY NO.

none

## 17. INFORMANT

Address Chevy Chase, MD  
Mrs. T. Harold Scott 4125 Leland St.INTERVAL BETWEEN  
ONSET AND DEATH

Leland

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY  
(IMMEDIATE CAUSE) (a)

4

DUE TO

(b)

DUE TO

(c)

but unable to breath  
Cortisic Sclerofis HP  
and fibrillation

Leland

10 yrs.

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.20d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that the hospital attended the deceased from 30 years to hearing present  
saw the deceased alive on June 10, 1966, and that death occurred at 6 A.M. from the causes and on the date stated above

## 22a. SIGNATURE

Dame Irving Brothman

M.D. ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS.   
22b. DATE SIGNED  
6-12-6622c. PHYSICIAN'S  
NAME (Type)

IRVING BROTHMAN

22d. ADDRESS  
1746 K ST. N.W., Washington, D. C.

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 23b. DATE THEREOF

June 15, 1966

## 23c. NAME OF CEMETERY OR CREMATORI

Glenwood Cemetery

## 23d. LOCATION (City, town or county)

Washington, D. C.

(State)

## 24. FUNERAL DIRECTOR'S SIGNATURE

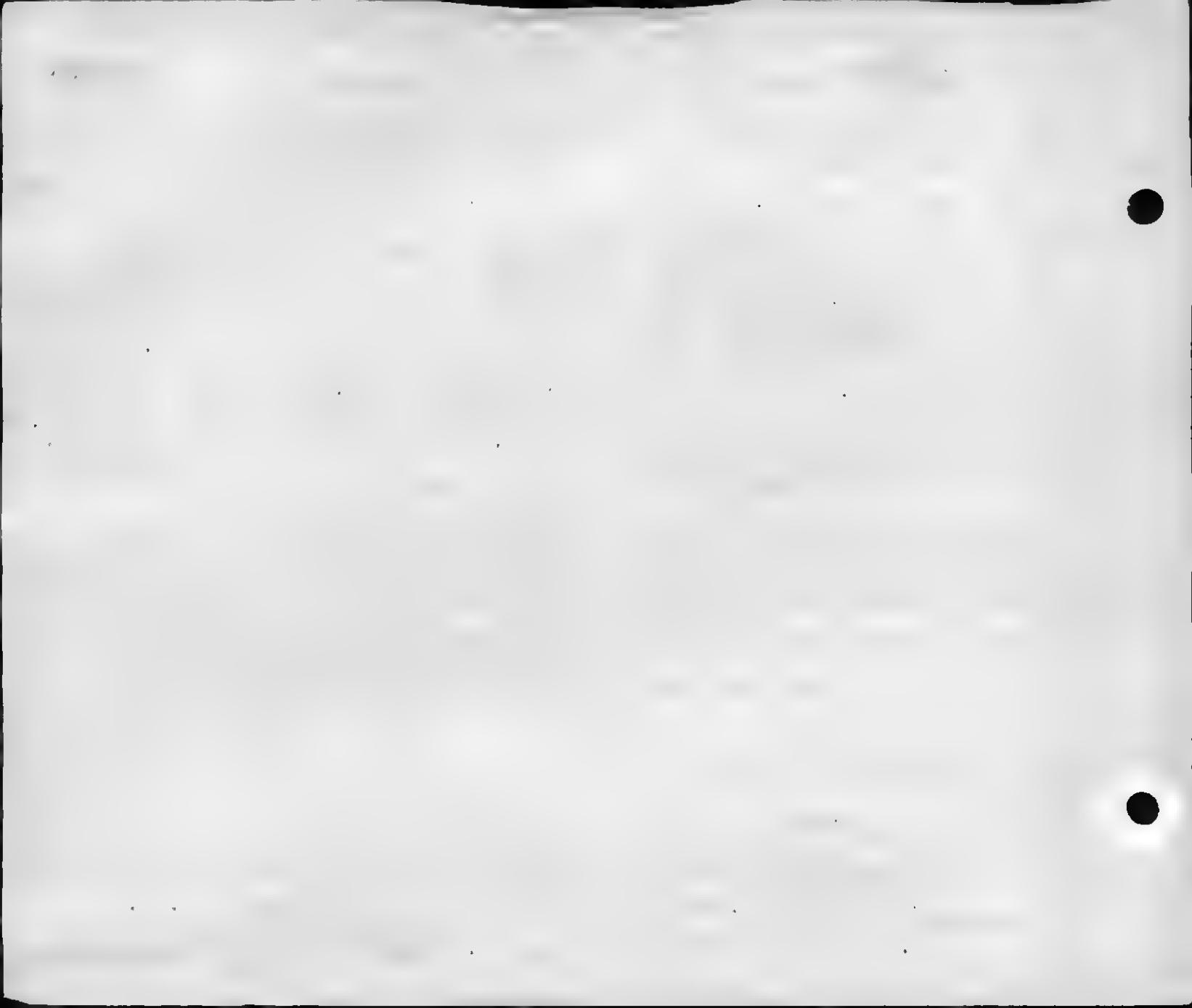
ADDRESS  
The S. H. Hines Company 2901 14th St. N.W. JUN 15 1966

25a. REC'D BY REGISTRAR

JUN 15 1966

Charles Judge

REGISTRAR'S SIGNATURE



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1

M

CE687

## CERTIFICATE OF DEATH

08677

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) <i>Silver Spring</i>						
c. LENGTH OF STAY IN 1b <i>50 hours</i>		d. STREET ADDRESS <i>836 Sligo Ave</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Whsh. San + Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Teresa Florence Meigher</i>		First	Middle					
		Last	14. DATE OF DEATH <i>June 6 1966</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-26-1894</i>	9. AGE (In years last birthday) <i>71 yrs</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beautician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Beauty Shop</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Isaac Goldaday</i>		14. MOTHER'S MAIDEN NAME <i>Alice S. Dodson</i>		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-38-4333</i>		17. INFORMANT <i>Patient's Chart.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>443X</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>(b)</i>		DUE TO <i>(c)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						YRS.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i> 19		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Nat While <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>6/19/66</i> to <i>6/6</i> , that (I) (we) last saw the deceased alive on <i>6/5 1966</i> , and that death occurred at <i>1254 M.</i> from causes and on the date stated above.						22b. DATE SIGNED <i>6/6/66</i>		
22a. SIGNATURE <i>Albert H. Gollman</i>		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Title) <i>ALBERT H. GOLLMAN, M.D.</i>		22d. ADDRESS <i>10943 Bldg 8100 67 Silver Spring Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>6-8-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL HOME <i>Cedar Hill Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Montgomery Md</i>		
24. FUNERAL DIRECTOR <i>Robert A. DeSole</i>		ADDRESS <i>DeSole Funeral Home D.C.</i>		25a. REC'D BY REGISTRAR <i>JUN 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

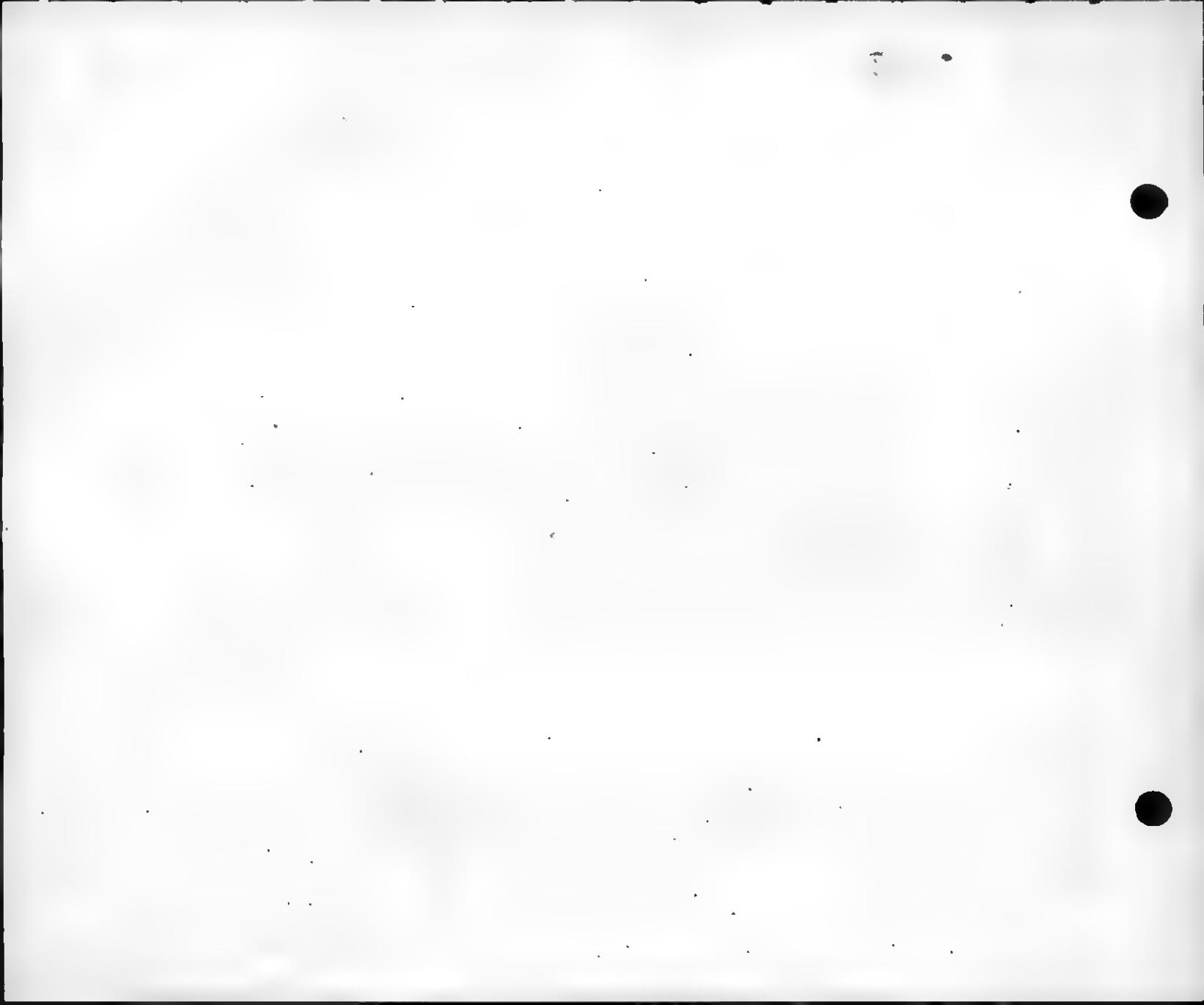
08678

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
Archy J. Weis, M.D. & Joe. Bloom M.D. Office located Patient since March 1961

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Montgomery				a. STATE Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Re admission		b. COUNTY Ga. Geo. Co.	
Takoma Park					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Washington Sanitorium & Hospital		900 Larch Avenue		Takoma Park	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First HAROLD	Middle FRANCIS	Last MELICK	4. DATE OF DEATH June 24 1966
5. SEX Male		6. COLOR, OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1905	9. AGE (in years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Sears Roebuck		10c. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
Division Head - Sales				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Homer Melick		14. MOTHER'S MAIDEN NAME Etoile Elizabeth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-05-9669		17. INFORMANT Mrs. Bertha M. Melick (same as #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15.1 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		Metastatic Carcinoma of Prostate			
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 24, 1966, that (I) (we) last saw the deceased alive on June 13, 1966, and that death occurred at 10:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE					
22b. DATE SIGNED June 24, 1966					
22c. PHYSICIAN'S NAME (Type) JOSEPH BLOOM		22d. ADDRESS 1015 Spring St. Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	
23d. LOCATION (City, town or county) Washington D.C.		(State)			
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St. N.W. Wash. D.C.		ADDRESS		25a. REC'D BY REGISTRAR JUN 27 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

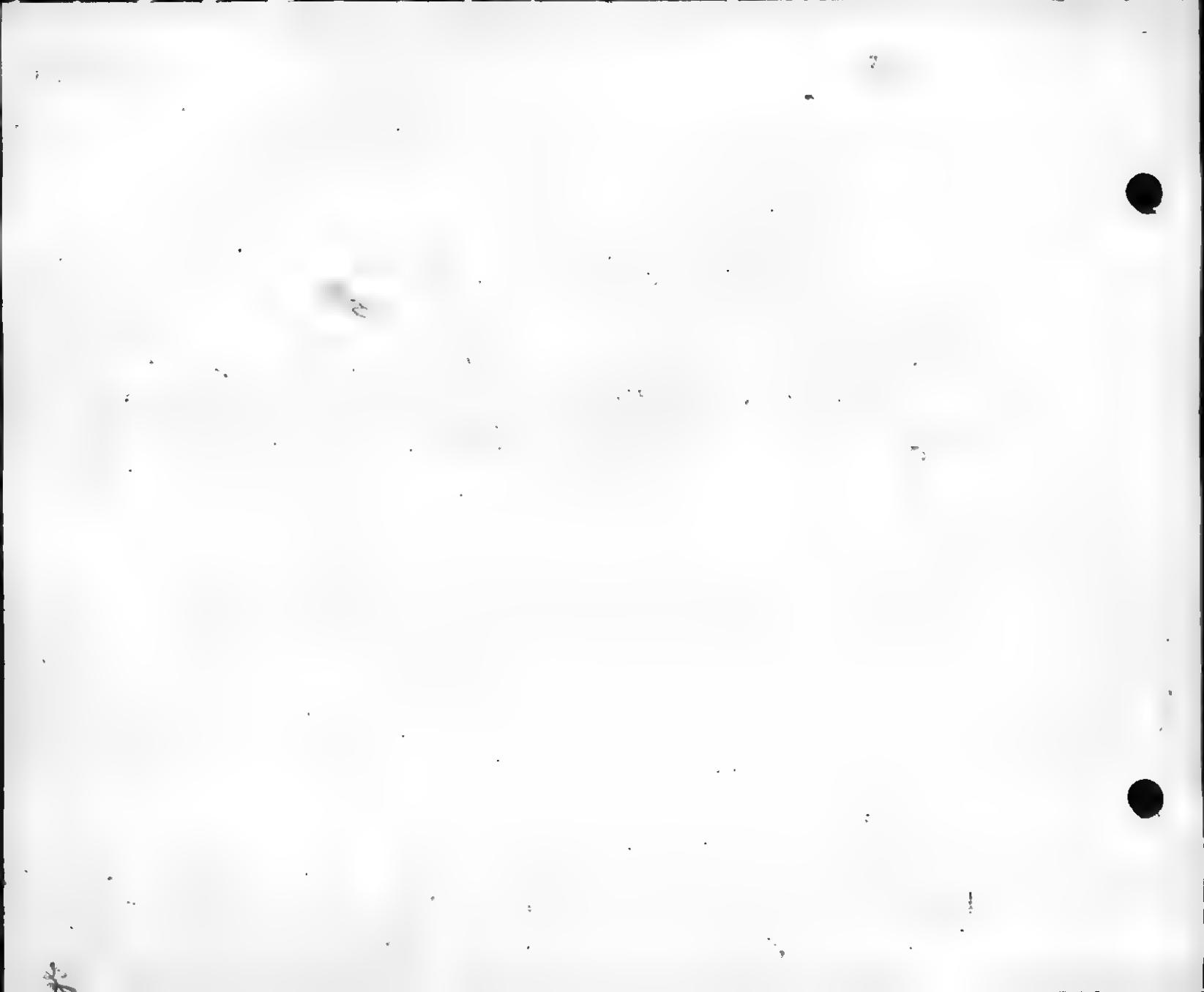
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
MONTGOMERY MARYLAND		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 32 Hrs		d. STREET ADDRESS 311 WATERFORD ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHARINE J.		4. DATE OF DEATH Last Name Meyer Month June Day 15 Year 1966	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED WIDOWED		8. DATE OF BIRTH NEVER MARRIED DIVORCED 8/10/03	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK J. MURPHY		14. MOTHER'S MAIDEN NAME CATHERINE CAHAWIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 064-03-2554	
17. INFORMANT J. LEO MEYER SAME AS #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro VASCULAR Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) ARTERIOSCLEROTIC VASCULAR DISEASE	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH @ 48 HRS	
20a. ACCIDENT WAS UNDERTAKING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15</u> , 1966, to <u>June 15</u> , 1966, that (I) (we) last saw the deceased alive on <u>June 15</u> , 1966, and that death occurred at <u>SFP</u> M, from the causes and on the date stated above.		22b. DATE SIGNED 6-15-66	
22a. SIGNATURE Bernard A. Fitzgerald		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 277 UNIVERSITY BLVD E, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-18-66	
23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.		23d. LOCATION (City, town or county) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Francis J. Callin 3821-14th St. Silver Spring, MD.		25a. REC'D BY REGISTRAR JUN 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Jard.			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

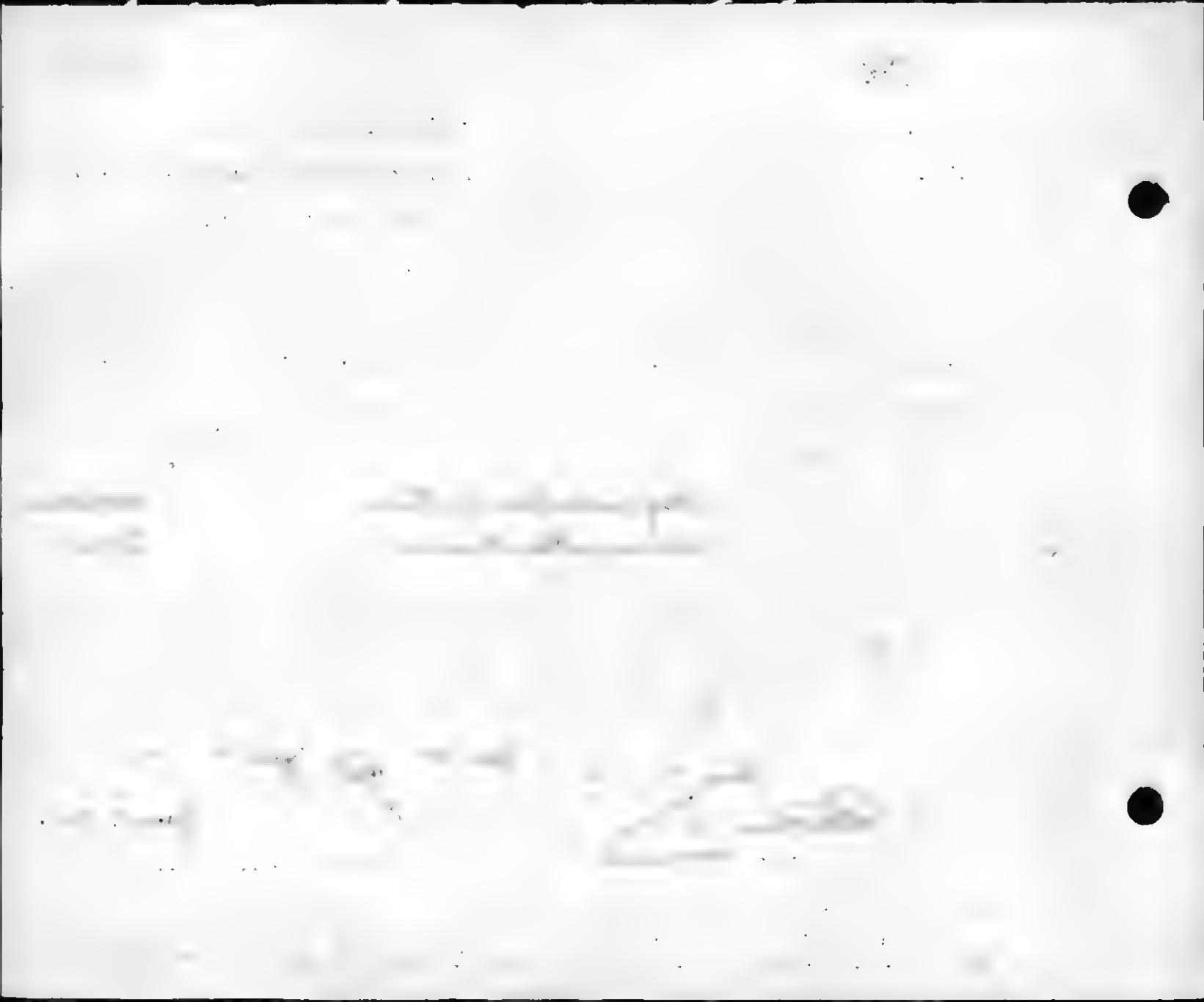
## CERTIFICATE OF DEATH

08680

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Country Chase</i>		c. LENGTH OF STAY IN 1b <i>4 1/2 hrs.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington D. C.</i>		b. COUNTY			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Bethesda Silver Spring Disc Home</i>		e. STREET ADDRESS <i>4135 New Hampshire Ave. N.W.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g. DATE OF DEATH <i>June 9 1966</i>					
3. NAME OF DECEASED (Type or print) <i>Mary E. Blaire</i>		First	Middle	Last	Month	Day	Year				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>XXXX 5-25-1880</i>	9. AGE (in years last birthday) <i>86 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Clerk</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Alexander Miller</i>		14. MOTHER'S MAIDEN NAME <i>Eleanor Henderson</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No None</i>		16. SOCIAL SECURITY NO. <i>Yes</i>		17. INFORMANT <i>Mrs. Louise Graves</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>	
										Address <i>5209 Abingdon Road West Hills, Md.</i>	
										INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
										2 years.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>June 29, 1966</i> , to <i>June 9, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 7, 1966</i> , and that death occurred at <i>448</i> M, from the causes and on the date stated above.		22b. DATE SIGNED <i>June 9, 1966</i>									
22a. SIGNATURE <i>Blair E. Blaire</i>		22d. ADDRESS <i>8641 Colesville Rd., S. S., Md.</i>									
22c. PHYSICIAN'S NAME (Type) <i>Blair E. Blaire</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 11, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rockcreek Cemetery</i>		23d. LOCATION (City, town or county) <i>Washington, D. C.</i>					
24. FUNERAL DIRECTOR <i>John D. Thomas</i>		ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>John 14 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
20M 1/65											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

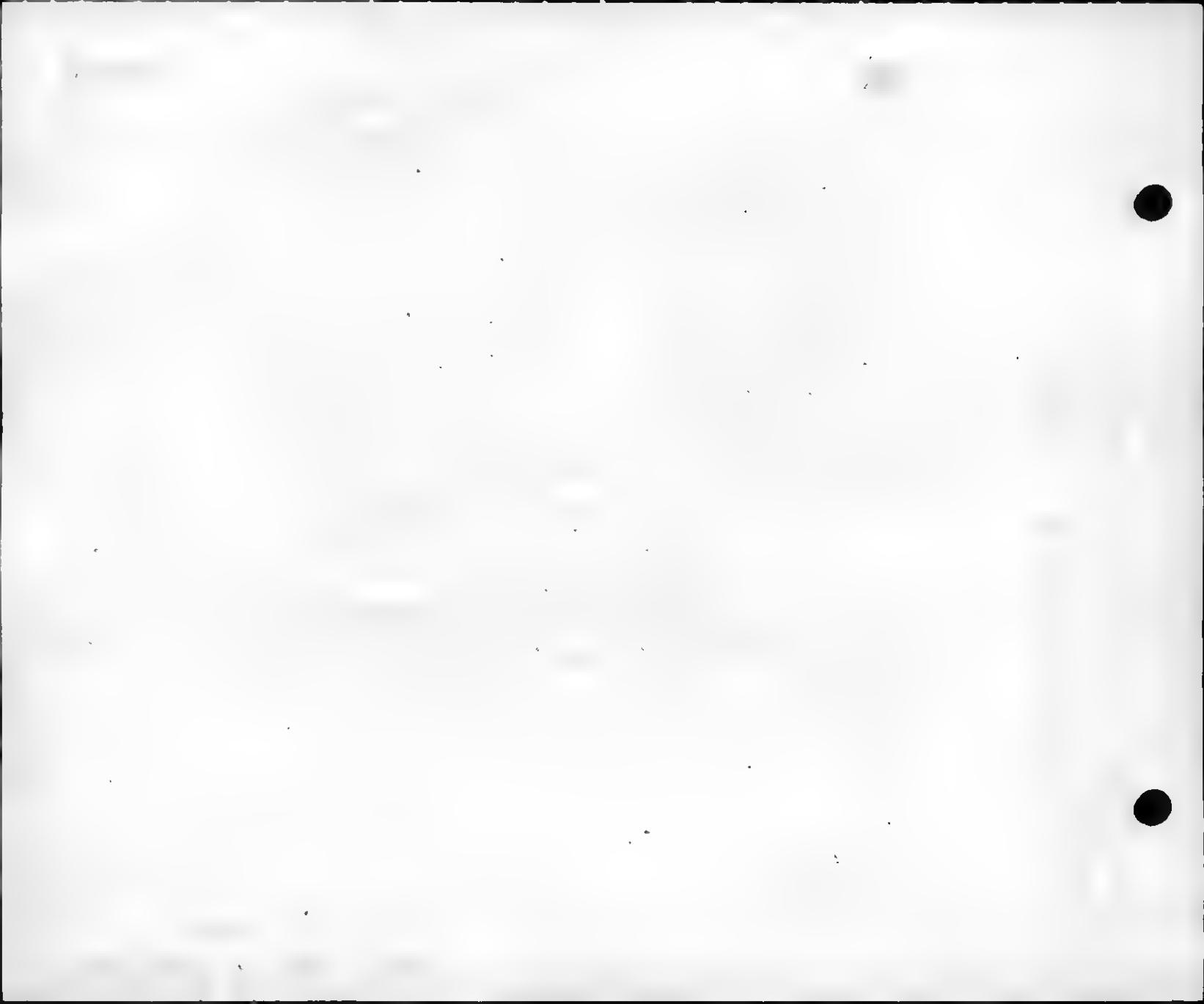
## CERTIFICATE OF DEATH

118681

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. The funeral director should file this certificate with the State Dept. of Health prior to burial/cremation, or remove and in any event, within 24 hours after death.

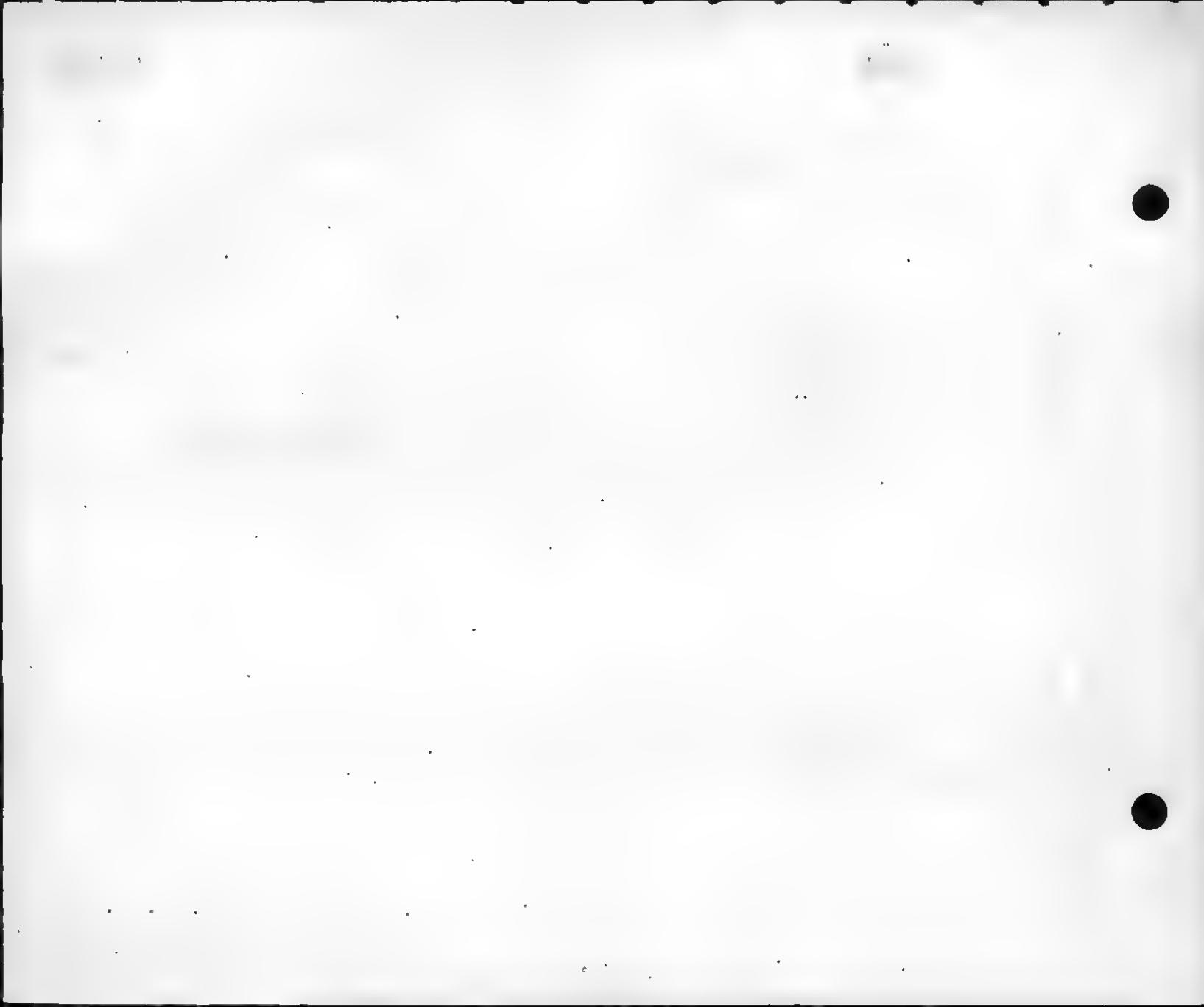
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) b. STATE											
Montgomery MARYLAND		Maryland Washington											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 3 days											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS Route #1											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)	Fist (Laura)	Middle Mabel	Last MOFFETT										
4. DATE OF DEATH	Month June	Day 9	Year 1966										
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH	10. AGE (In years last birthday)	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS Days	13. IF UNDER 24 HRS Hours	14. IF UNDER 24 HRS Min				
Female	Caucasian			January 2, 1881	85 yrs	—	—	—	—				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Teacher Home & School		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Brown, Minnesota		12 CITIZEN OF WHAT COUNTRY U.S. of Am.							
13. FATHER'S NAME Francis M. KENNEDY		14. MOTHER'S MAIDEN NAME Jerusha POST		Address Walter C. Moffett, Hagerstown, Md.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH							
		—		Walter C. Moffett		8 hours							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Failure											
X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		Anoxia						1 day					
		Bronchitis						1 wk.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Hemorrhagic Areas in Kidneys, Spleen Pancreas & Mediastinum										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.)											
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (This hospital) attended the deceased from March 7, 1961, to June 9, 1966, that (I) (we) last saw the deceased alive on June 9, 1966, and that death occurred at 2:13 AM, from causes and on the date stated above.													
22a SIGNATURE Walcutt W. Gibson		M.O. ATTENDING PHYS.		M.D. ME.D. DIRECTOR		STAFF PHYS.		22b. DATE SIGNED June 9, 1966					
22c. PHYSICIAN'S NAME (Type) Walcutt W. GIBSON		22d. ADDRESS 4300 St. Barnabas Rd., Washington D.C. 20031											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-11-66		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery		23d. LOCATION (City or Town) 5m. Smithsburg, Wash. Co. Md.		(County)			(State)		
24. FUNERAL DIRECTOR Andrew K COFFMAN Funeral Home Inc		Hagerstown ADDRESS Maryland		25a. REG'D BY REGISTRAR JUN 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 20 M 1/68													



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

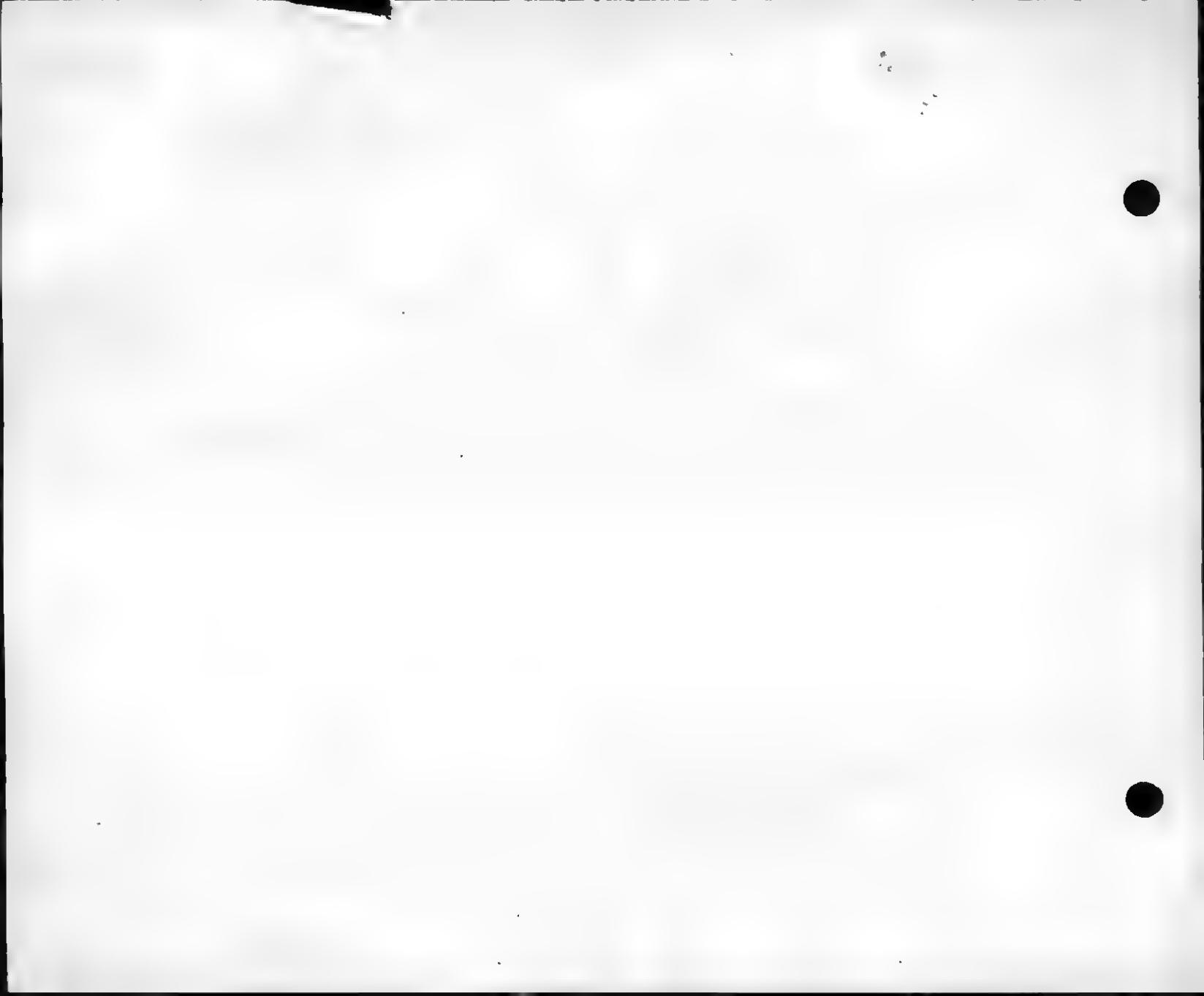
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												08682				
CERTIFICATE OF DEATH																
2. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)													
a. COUNTY			b. STATE													
Montgomery			MARYLAND													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b													
SILVER SPRING			9 Days.													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS													
HOLY CROSS Hosp.			2816 E Randolph St. Rd.													
e. IS RESIDENCE ON A FARM?			f. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
CLARA			A	MUELLER		6	3	19	66							
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH			9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min.
F			W						4/15/80			86 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?				
Housewife								D.C.				U.S.A.				
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME													
Louis Schade			Anna Creger													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address				
no								Miss Nellie McCoy same as above								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>												10 days				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CEREBROVASC. DIS</u>												YEARS				
(c)																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)							
21. I certify that (I) (We) attended the deceased from 5/25, 1966, to 6/3, 1966, that (I) (We) last saw the deceased alive on 6/3 1966, and that death occurred at 1 P.M., from the causes and on the date stated above.												22b. DATE SIGNED 6/4/66 M.H.				
22a. SIGNATURE <u>Richard H. Pollen</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLON MD</u>			22d. ADDRESS <u>10400 CONNECTICUT AVE KENSINGTON</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6/8/66</u>			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Prospect Hill Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>							
24. FUNERAL DIRECTOR <u>The S. N. H. Co. Wash. D.C.</u>			25a. REC'D BY REGISTRAR <u>JUN 8 1966</u>									25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
			DATE													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that at the death certificate be retained within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1B <b>2 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MARGARET HOLY CROSS HOSPITAL</b>				d. STREET ADDRESS <b>9201 NEW HAMPSHIRE AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>MARGARET</b>	Middle <b>Mary</b>	Last <b>Muller</b>	4. DATE OF DEATH Month <b>6</b>	Month <b>24</b>	Day <b>19</b>	Year <b>66</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-19-83</b>	9. AGE (In years last birthday) <b>88 82 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Worker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Aero nautics</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>Richard C. Muller</b>		14. MOTHER'S MAIDEN NAME <b>Sophie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>246-46-0521</b>		17. INFORMANT <b>John R. Muller, Adelphi, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock + anemia 2°</b>		Address <b>2100 Lackawanna Street</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		OUE TO (b) <b>Ruptured abdominal aortic aneurysm</b>	DUE TO (c) <b>anterior embolism</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b>		(County) <b>Montgomery</b>		(State) <b>Maryland</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>6/22</b> , 1966, to <b>6/24</b> , 1966, that (I) (we) last saw the deceased alive on <b>6/24</b> , 1966, and that death occurred at <b>11:25 AM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Joseph F. Schanno</b>		22b. DATE SIGNED <b>June 24, 1966</b>											
22c. PHYSICIAN'S NAME (Type) <b>Joseph F. Schanno</b>		22d. ADDRESS <b>8218 Wisconsin Ave, Bethesda</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 28, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town or county) <b>Montgomery, Maryland</b>		(State)					
24. FUNERAL DIRECTOR <b>Joseph Thomas Warner E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue, Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

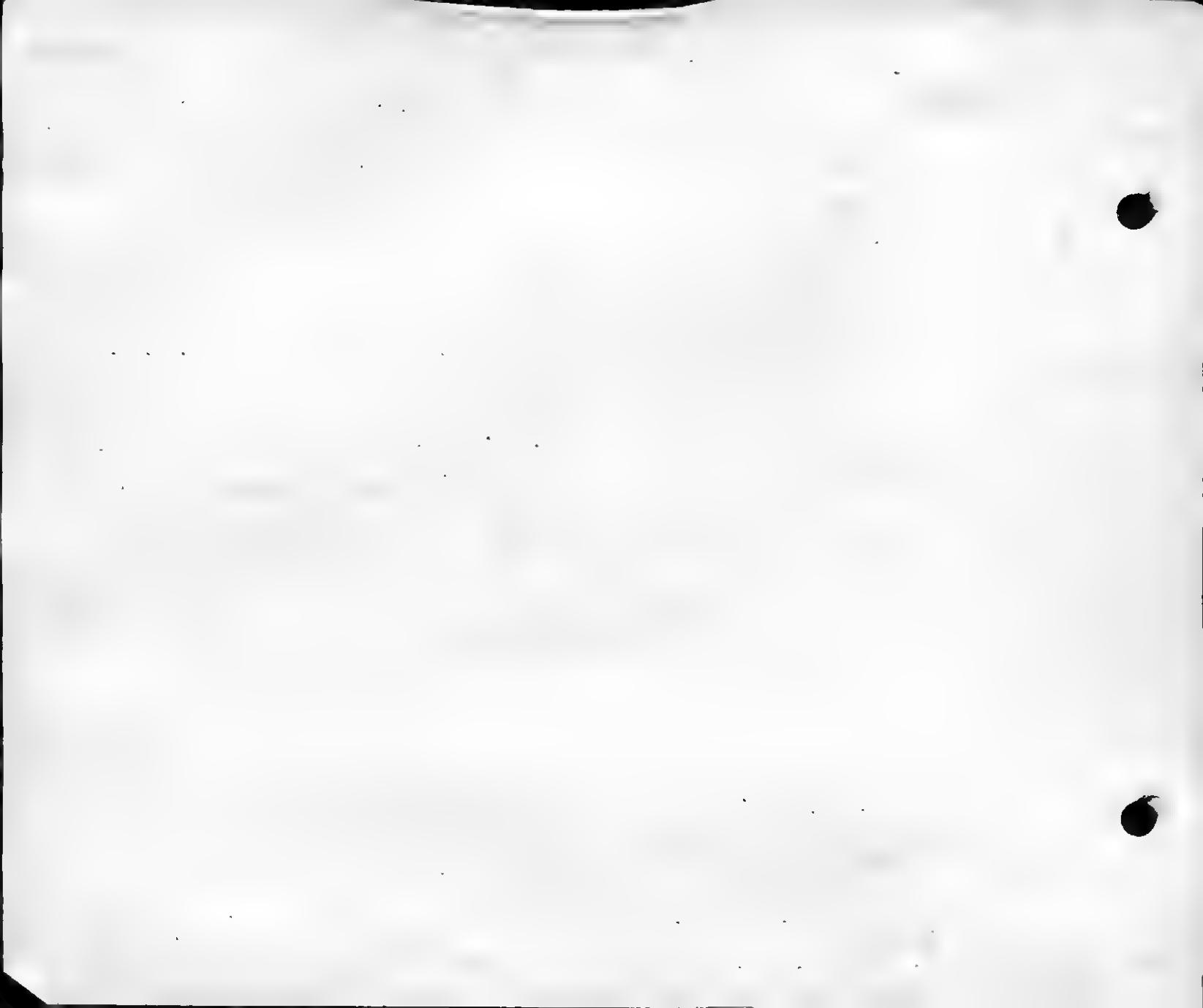
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

118684

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH CC 696 Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 1607 Cody Drive						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1607 Cody Drive				d. STREET ADDRESS 1607 Cody Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MARY		First	Middle	19	4. DATE OF DEATH June	Month	Day	Year 9 1966				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-83	9. AGE (In years at 1st birthday) 82 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Albany, New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME James J. Dwyer				14. MOTHER'S MAIDEN NAME Ellen Maher								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT 219-54-9645 Mrs. Marion U. Gaegler		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteoarthritis						
						19. INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) Oct 1953 to Feb 26, 1966	(County)	(State)
21. I certify that (I) (the hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that death occurred at _____ M. from the causes and on the date stated above										22b. DATE SIGNED 6/9/66		
22a. SIGNATURE George B. Patrick Jr.		M. D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) GEORGE B. PATRICK, JR. MD		23d. LOCATION (City, town, or county) Washington, D. C.		(State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 1966		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		23d. LOCATION (City, town, or county) Washington, D. C.		23e. (State)				
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR JUN 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

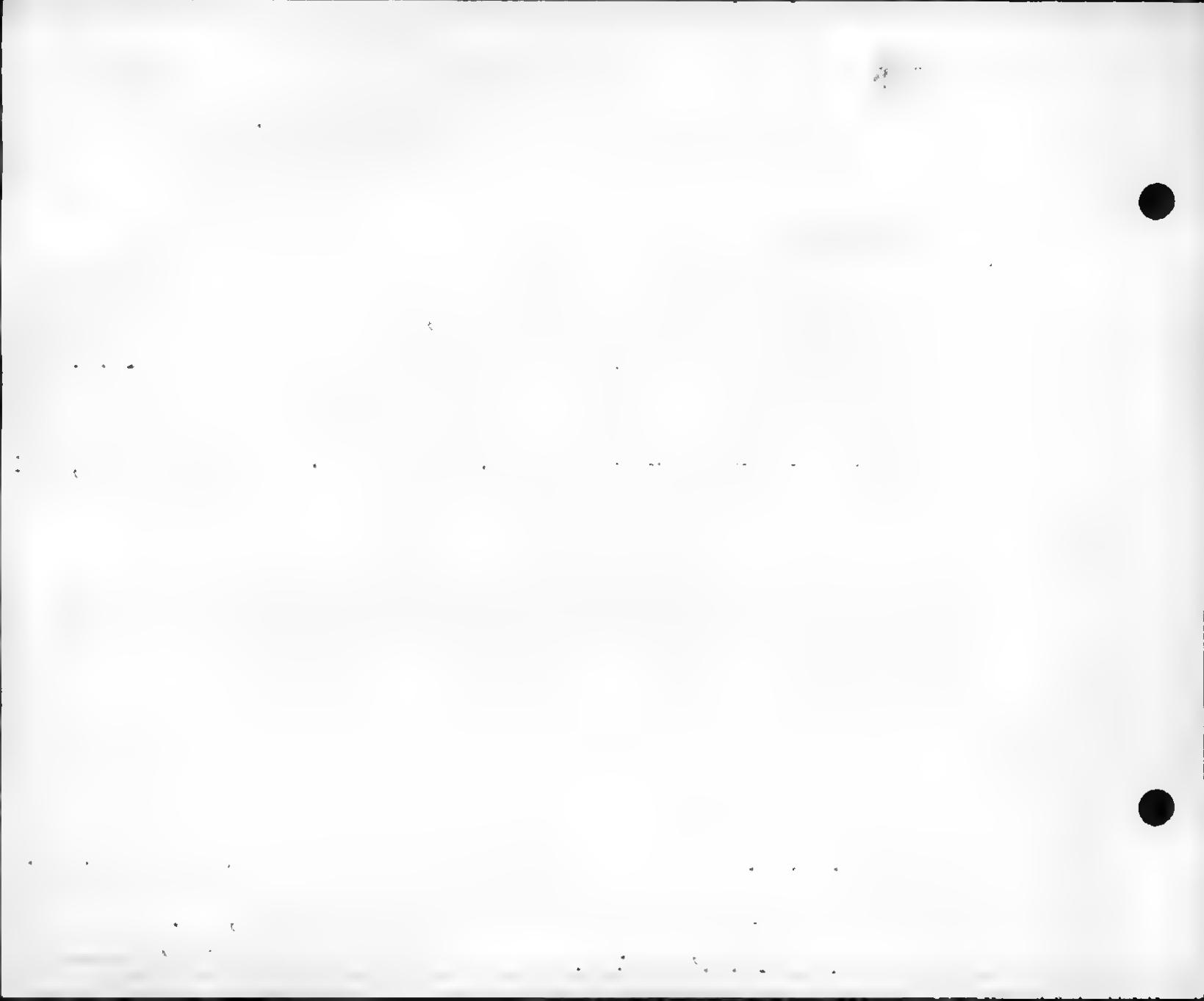
118655

300695

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 110 Northbrook Lane		d. STREET ADDRESS 110 Northbrook Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Fannie L	Middle Murray	Lost	4. DATE OF DEATH June 19 1966	Month	Doy	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min
10. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Henry Murray			14. MOTHER'S MAIDEN NAME Margaret Ward				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-30-4779		17. INFORMANT Mrs. Franklin F. Haller		Address 110 Northbrook La. Bethesda Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO <u>Diabetes mellitus</u> (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20. MEDICAL CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>6/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>66</u> , and that death occurred at <u>4:45 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>W. T. Joyce</u>				22b. DATE SIGNED 6/19/66			
22c. PHYSICIAN'S NAME (Type) Dr. W. T. Joyce		22d. ADDRESS 4877 Battery Lane, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-22-1966		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc. 5130 Wisc. Ave. N.W., Wash. DC.				ADDRESS		25a. REC'D BY REGISTRAR JUN 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

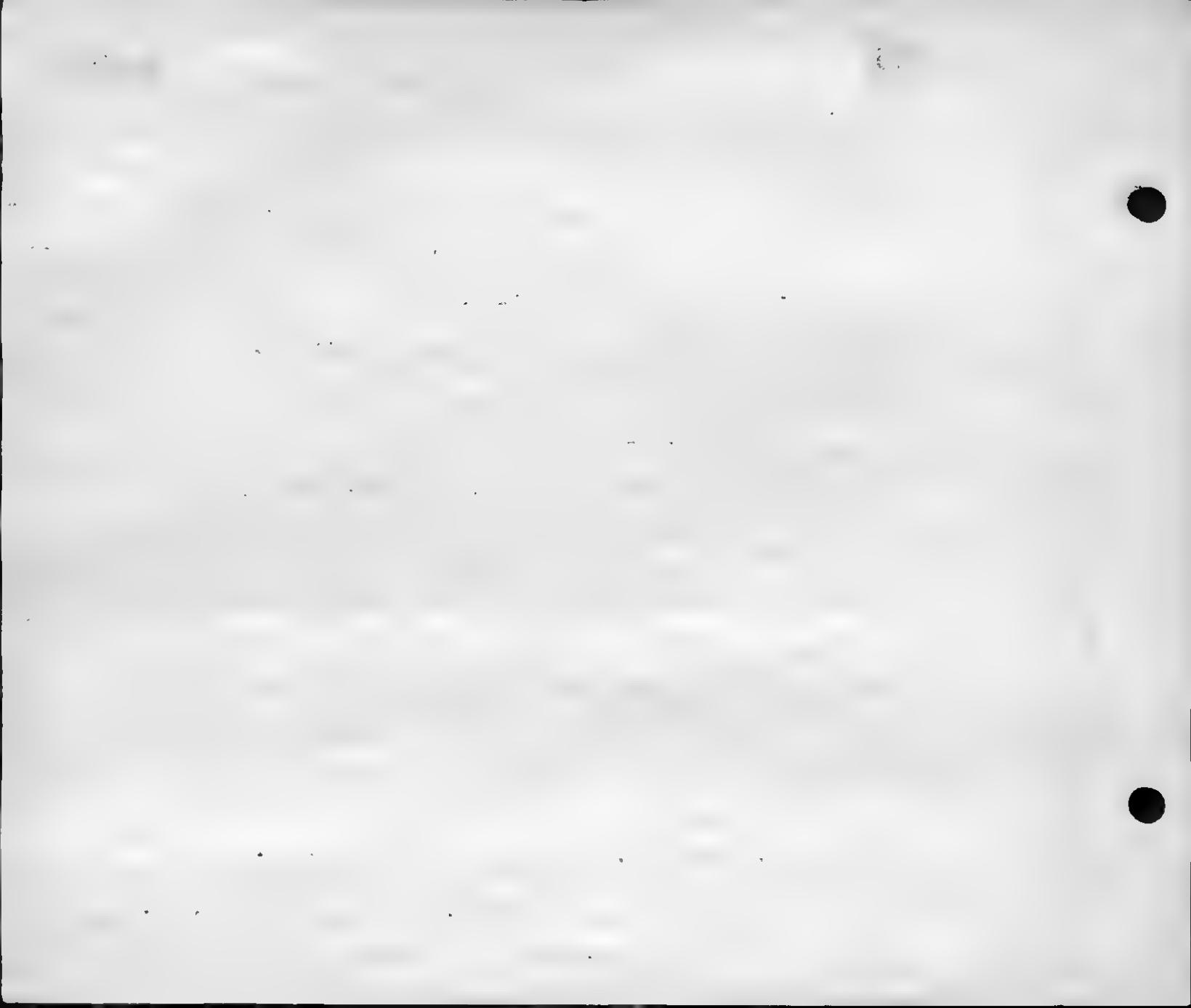
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08696

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DAMASCUS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>P. O. Box 285, Rt. 3 Mt. AIRY</b>	
3. NAME OF DECEASED (Type or print) <b>NELLIE</b>		First <b>NELLIE</b>	Middle <b>EDNA</b>
4. DATE OF DEATH Month <b>6</b>		Month <b>28</b>	Day Year <b>19 66</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <b>7-25-1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>FREDERICK COUNTY, Mo.</b>
13. FATHER'S NAME <b>WILLIAM J. CLAY</b>		14. MOTHER'S MAIDEN NAME <b>ALICE RUNKLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-22-2397</b>	17. INFORMANT Address <b>MEDICAL RECORDS</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) (c)		Coronary occlusion, myocardial infarction Arteriosclerotic cardiovascular disease Diabetes mellitus	
19. INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>		10 years 6 years	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work <input type="checkbox"/> at work <input type="checkbox"/>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> , 19 <b>58</b> to <b>6/1/66</b> , 19 <b>66</b> , that (I) ( ) last saw the deceased alive on <b>6/1/66</b> , 19 <b>66</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>6/3/66</b>	
22a. SIGNATURE <b>James P. Kerr</b>		ATTENDING PHYS. <b>M.D.</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>JAMES P. KERR, M. D.</b>		22d. ADDRESS <b>Damascus, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 1, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Providence Meth.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molesworth</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 5 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

38697

## CERTIFICATE OF DEATH

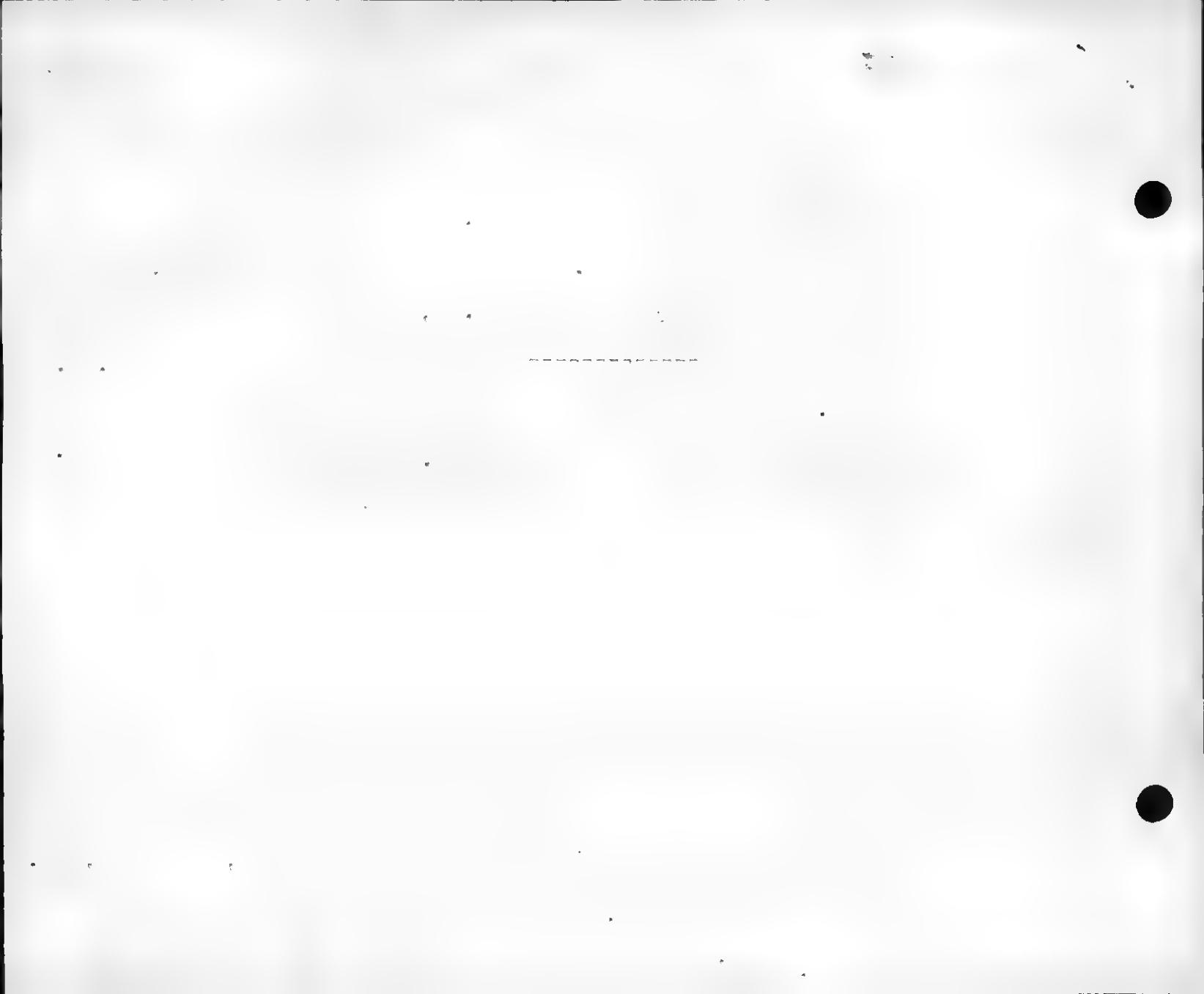
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>11807 Rockingham Road</b>		
3 NAME OF DECEASED (Type or print) <b>ESTHER H. NAVE</b>		4 DATE OF DEATH <b>June 1, 1966</b>	Month Day Year	
S SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 1, 1895</b>	
10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9 AGE (in years last birthday) <b>70</b> yrs	11. IF UNDER 1 YEAR Months Days Hours Min.	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Winchester, Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George E. Hillyard</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Mae Affleck</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO	17. INFORMANT <b>Daughter</b> Address <b>Elsie M. Roberts</b> Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral Arterosclerosis 6 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> (c) <i></i>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i> (County) <i></i> (State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>1965</i> to <i>1 June, 1966</i> , that (I) (we) last saw the deceased alive on <i>31 May 1966</i> , and that death occurred at <i>3:01 PM</i> , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <i>John J. Dunn</i>		ATTENDING PHYS 22d. ADDRESS <i>4977 Battery Lane, Bethesda, Md.</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1 Jan 66</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-4-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Hebron Cemetery</b>	23d. LOCATION (City or Town) <b>Winchester, Virginia</b> (County) <b>Virginia</b> (State)
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>JUN 3 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH  
a. COUNTY **Montgomery** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Takoma Park**

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Washington Sanitarium + Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE **Maryland** b. COUNTY **Montgomery**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Takoma Park**

d. STREET ADDRESS **8310 Greenwood Avenue**

e. IS RESIDENCE ON A FARM? YES  NO

3. NAME OF DECEASED (Type or print) **Francis David Nichol**

First **Francis** Middle **David** Last **Nichol**

4. DATE OF DEATH JUNE 3 1966

5. SEX **MALE** 6. COLOR OR RACE **White** 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH **2-14-97** 9. AGE (in years) **69** yrs. 10. KIND OF BUSINESS OR INDUSTRY

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Editor - Minister**

10b. BIRTHPLACE (County & State, or foreign country) **Australia** 11. BIRTHPLACE (County & State, or foreign country) **United States**

12. CITIZEN OF WHAT COUNTRY? **United States**

13. FATHER'S NAME **John Nichol** 14. MOTHER'S MAIDEN NAME **Mary Pearson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. 17. INFORMANT **Chart**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **451X** DUE TO **Cardiac tamponade** INTERVAL BETWEEN ONSET AND DEATH **< 24 hrs**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO **Dissecting Aneurysm**

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES  NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
Hour a.m. While at work Not While at work  
p.m. 19

21. I certify that (1) (this hospital) attended the deceased from **6-2**, 19**66**, to **6-3**, 19**66**, that (1) (we) last saw the deceased alive on **6-3**, 19**66**, and that death occurred at **11-28** AM, from the causes and on the date stated above.

22a. SIGNATURE **R. H. Sandstrom** 22b. DATE SIGNED **6-3-66**

22c. PHYSICIAN'S NAME (Type) **R. H. Sandstrom MD** 22d. ADDRESS **7701 Carroll Ave, Takoma Park, Md**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **June 6, 1966** 23c. NAME OF CEMETERY OR CREMATORIAL **George Washington** 23d. LOCATION (City, town or county) (State) **Adelphi, Prince George's Co, Md**

24. FUNERAL DIRECTOR **Walters Funeral Home** 254 Carroll St NW, DC 25a. REC'D BY REGISTRAR **JUN 6 1966** 25b. REGISTRAR'S SIGNATURE **Charles Judge**

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. That please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY										
a. COUNTY <i>Montgomery</i>				b. STATE <i>Maryland</i>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>										
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <i>1907 Charleston Pl.</i>										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sav Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)				First <i>John</i>	Middle <i>Thomas</i>	Last <i>Oakley</i>	4. DATE OF DEATH	Month <i>June</i>	Day <i>4</i>	Year <i>1966</i>				
5. SEX <i>MALE</i>				6. COLOR OR RACE <i>CAUCASIAN</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-13-87</i>	9. AGE (In years last birthday) <i>79</i>	IF UNDER 1 YEAR Months <i>yrs.</i>	IF UNDER 24 HRS. Hours <i>Days</i>	IF UNDER 24 HRS. Hours <i>Min.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Cabinet maker</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thomas Oakley</i>				14. MOTHER'S MAIDEN NAME <i>Rose</i>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Chart</i>				Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <i>Cardio-pulmonary failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6/7/66-6/7/66</i>										
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Acute myocardial infarction &amp; (c) Mesenteric thrombosis</i>				DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) <i>6/7/66</i>				20f. (City or town) <i>6/6</i>	(County) <i>6/6</i>	(State) <i>6/6</i>
21. I certify that (I) (this hospital) attended the deceased from <i>6/7/66</i> to <i>6/6</i> , that (I) (we) last saw the deceased alive on <i>6/6</i> , and that death occurred at <i>6/6</i> M from the causes and on the date stated above.														
22a. SIGNATURE <i>Ben Shulman</i>														
22b. DATE SIGNED <i>6/7/66</i>														
22c. PHYSICIAN'S NAME (Type)				ATTENDING M.D. PHYS. <input type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>6-7-66</i>				23c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>				23d. LOCATION (City, town or county) <i>Bladensburg</i>		(State) <i>Maryland</i>
24. FUNERAL DIRECTOR ADDRESS Wilhelm Funeral home 4307 S. Highland St. S. Highland Maryland														
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>														



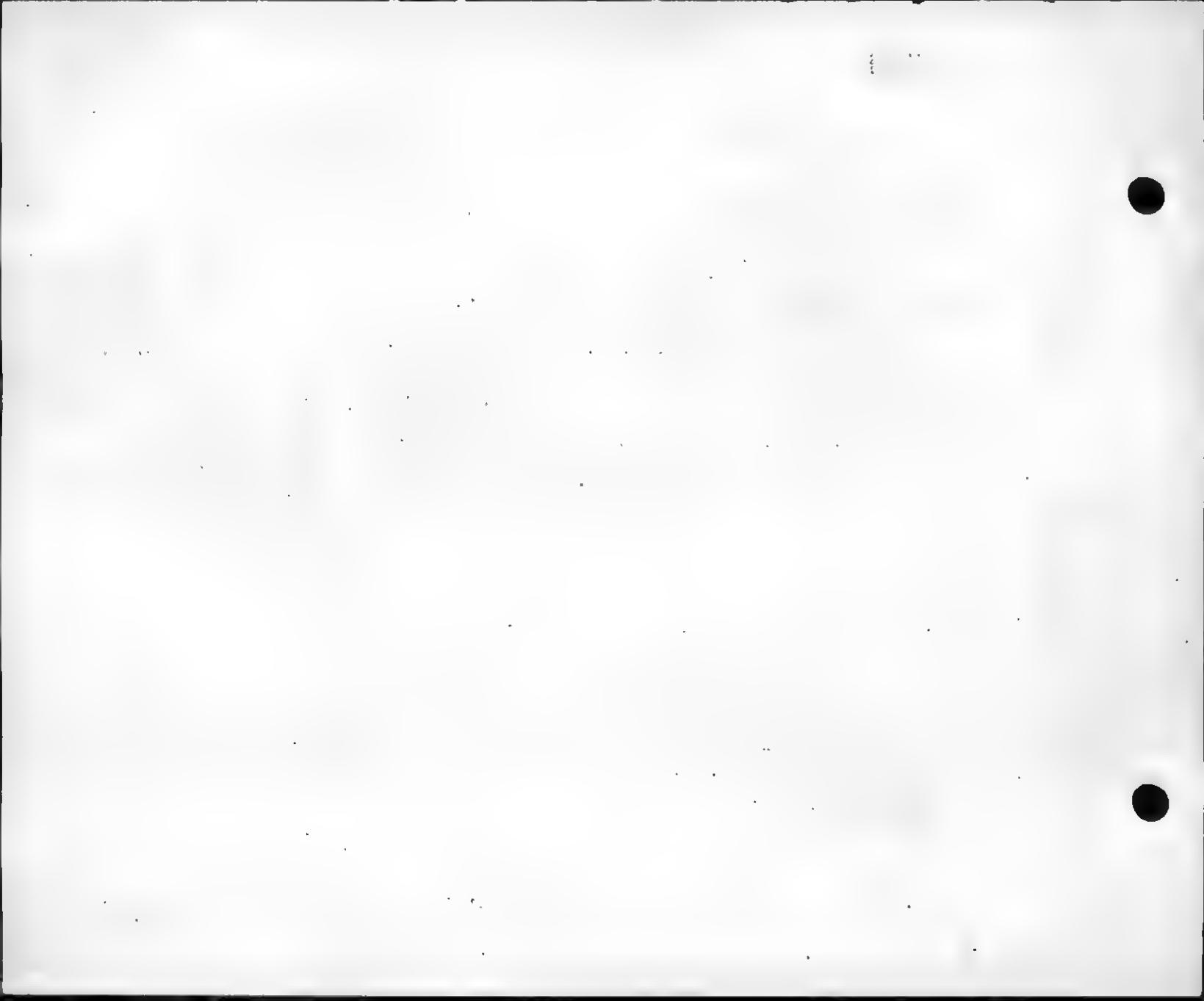
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MMARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
Montgomery MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 12607 Bluehill Road	
c. LENGTH OF STAY IN 1b		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bel Pre Nursing Home			
3. NAME OF DECEASED (Type or print)	First PAULINE	Middle G.	Last OLIN
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Moses Judah		14. MOTHER'S MAIDEN NAME Esther Goldstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. None 17. INFORMANT Ralph Olin Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO CEREBROVASCULAR ACCIDENT (STROKE) INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE 5+ YEARS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MULTIPLE STROKES GENERALIZED ATHEROSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) <u>the hospital</u> attended the deceased from <u>DEC 1959</u> to <u>JUNE 24, 1966</u> , that (I) <u>last</u> saw the deceased alive on <u>JUNE 24, 1966</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward A. Beeman</u> 22b. DATE SIGNED <u>JUNE 24, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-26-66</u> 23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Ararat Cemetery</u>	
24. FUNERAL DIRECTOR <u>Holberry Funeral Home</u>		23d. LOCATION (City, town or county) (State) <u>Pinelawn, L.I., N.Y.</u>	
		25a. REC'D BY REGISTRAR <u>JUN 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or ~~cremation~~ and in any event, within 72 hours after death.

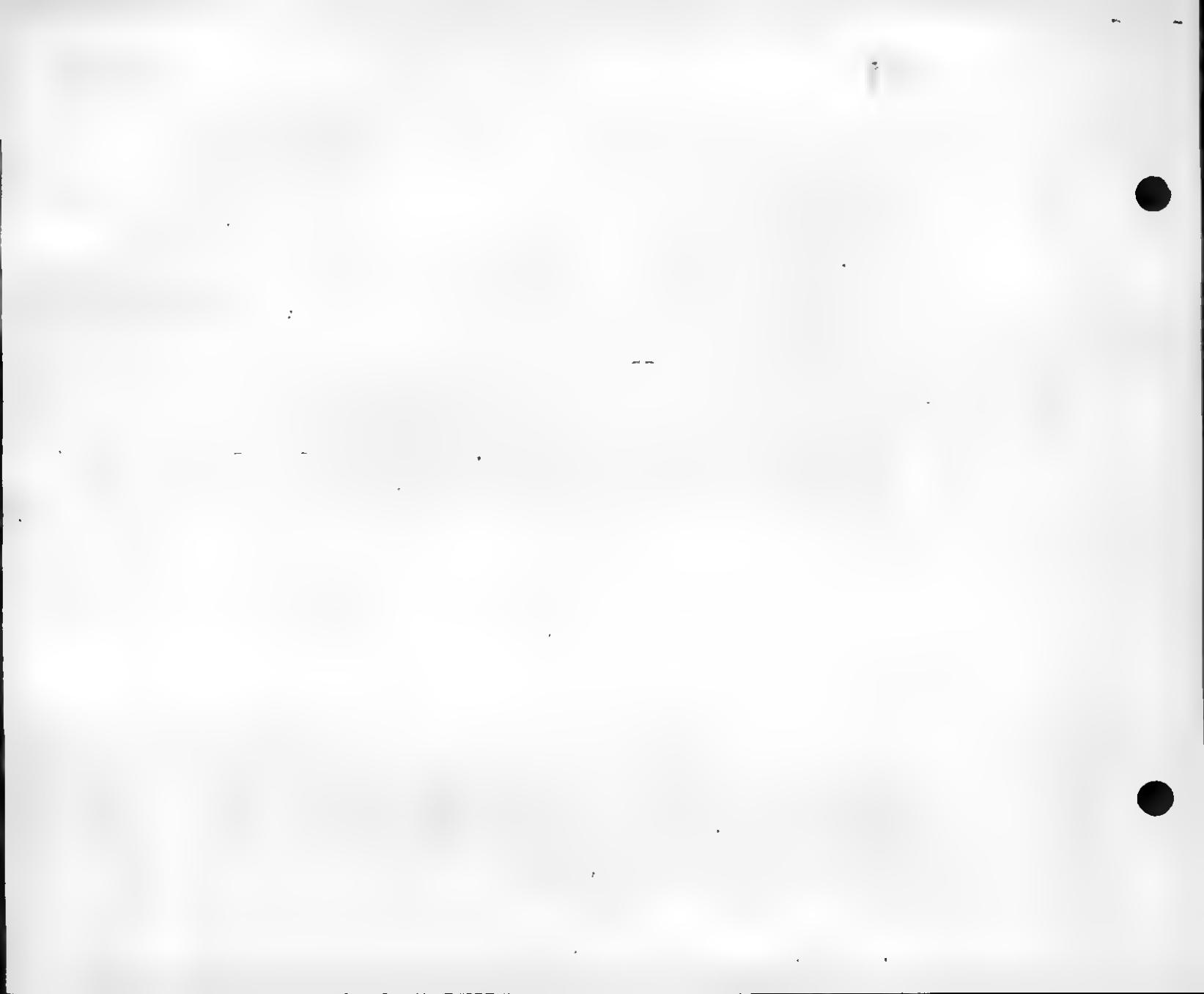
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Montgomery MARYLAND		Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 5 wks + 2 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reservoir Sanitarium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
3. NAME OF DECEASED (Type or print)		First	Middle			
Wilson E.			Osburn			
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	8. DATE OF BIRTH Feb 17th 1882			
m	w	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	9. AGE (In years lost birthday) 84 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Government Employee		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (County & State, or foreign country) West Virginia			
13. FATHER'S NAME Alvin Osburn		12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Mrs. Rosa Osburn - Wife - Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		19. INTERVAL BETWEEN ONSET AND DEATH 6/29/1966 ?				
DUE TO DUE TO DUE TO		Cerebrovascular accident Cerebral arteriosclerosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Suspected bronchopneumonia.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) 6/23/1966 to 6/29/1966	(County) 1966	(State) 1966
21. I certify that (I) (this hospital) attended the deceased from 5-23-1966 to 6-29-1966 that (I) (we) last saw the deceased alive on 6-28-1966, and that death occurred at 602 M. from causes and on the date stated above.				22b. DATE SIGNED 6/29/1966		
22c. PHYSICIAN'S NAME (Type) George A. Gray, Jr. MD		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Chevy Chase, Montgomery, Md.			
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE THEREOF 7/1/1966	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	23d. LOCATION (City or Town) Prince Georges	(County) Maryland	(State)
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE JUL 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		



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FOR STATE  
HEALTH DEPT.

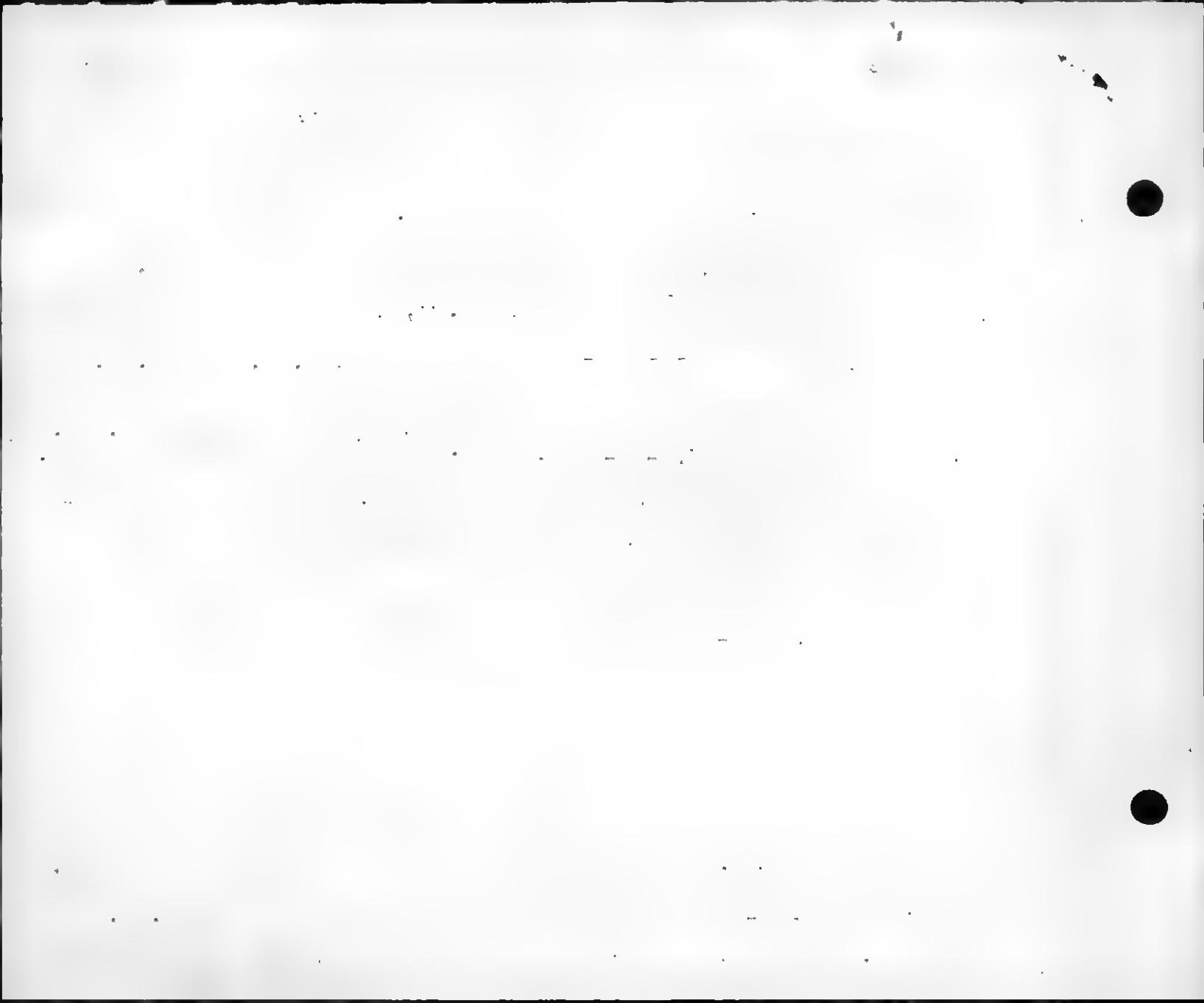
**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <b>Montgomery MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>									
c. LENGTH OF STAY IN 1b <b>12 years</b>			d. STREET ADDRESS <b>3939 Newdale Road</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3939 Newdale Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>BERTHA COLEMAN</b>			4. DATE OF DEATH <b>June 19, 1966</b>	Month	Day	Year						
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1882</b>	9. AGE (in years last birthday) <b>83 yrs.</b>	10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 NRS Days <b>22</b>	12. Hours <b>1</b>	13. Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY -----			11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>William Coleman</b>			14. MOTHER'S MAIDEN NAME <b>Jeannie Boone</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>577-30-5684-B</b>			17. INFORMANT <b>Daughter</b> 8915 Montg. Ave. <b>Mrs. Mason Weadon-Chevy Chase, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b>			Coronary Insufficiency Acute									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) Hypertensive cardiovascular Disease			Years						
			DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Osteo-Arthritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>White</b> 20d. INJURY OCCURRED p.m. <b>19</b> at work <input type="checkbox"/> et work <input type="checkbox"/>					20f. (City or town) <b>Washington, D. C.</b> (County) <b>Bethesda</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			22. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <b>6/19/66</b>						
ACTUAL SIGNATURE <i>John G. Ball</i>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>			Address (Street, city, town, or county) <b>Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>6-22-66</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Washington, D. C. Md.</b>			
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>JUN 21 1966</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "word "punting" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
WALT DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Forms Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

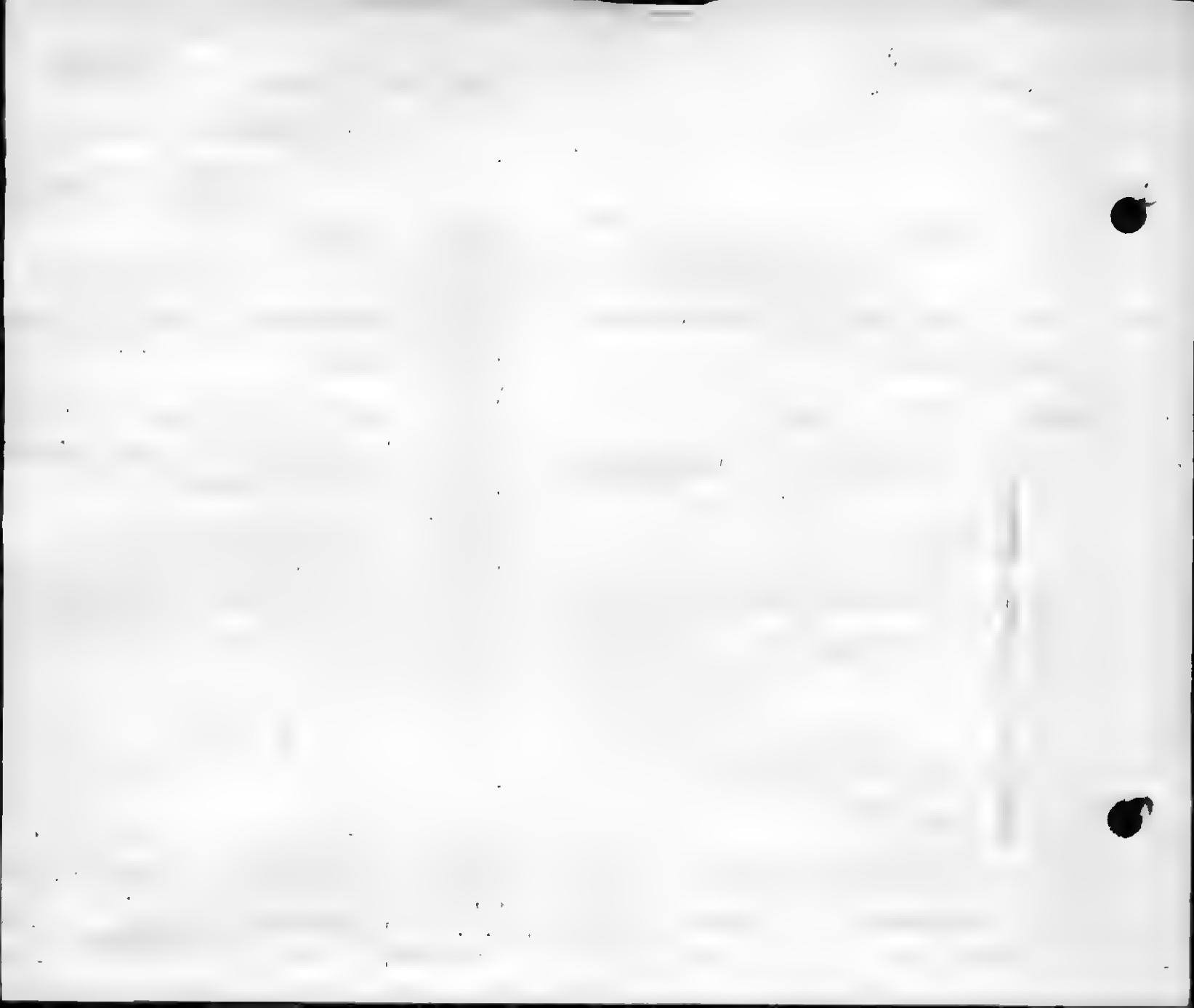
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08703

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08693

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		b. COUNTY Montgomery	
c. LENGTH OF STAY IN lb 1 1/2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 3201 16th Street	
3. NAME OF DECEASED (Type or print) Frank		First	Middle
4. DATE OF DEATH Paley	Month June	Day 8	Year 1966
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/07	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker, real estate		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Paley		14. MOTHER'S MAIDEN NAME Rachel?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Son, Stephen Paley		Address 10201 Grosvenor Pl. Rkvl., Md	
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/201 DUE TO Conditions, if any, which give rise to immediate cause (b) } (c) } (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Acute Coronary Insufficiency Coronary Artery Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) R. REED M.D. Wheaton	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 6/10/66	
22c. NAME OF CEMETERY OR CREMATORIUM King David Mem. Garden Falls Church, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR B. Danzansky and Sons		ADDRESS 3501-14th St. N.W.	24a. REC'D BY REGISTRAR JUN 13 1966
24b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Montgomery MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 16 hr?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 116 Carlo Street		d. STREET ADDRESS 511 Bickford Lane	
3. NAME OF DECEASED (Type or print)		First	Middle
George		Alger	Palmer
4. DATE OF DEATH		Month	Day Year
JUNE 12 1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M Colored			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Fred Palmer		Carrie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage, massive</u>		INTERVAL BETWEEN ONSET AND DEATH ½ hour	
DUE TO (b) Trauma to old head injury		½ hour	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute and chronic alcoholism			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell out of chair-struck site of old injury of head	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:00</u> p.m. 6/11 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rockville Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 6/12/66	
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National	
23c. LOCATION (City, town or county) (State) Arlington, Va.		23d. REC'D BY REGISTRAR	
24a. FUNERAL DIRECTOR <i>Robert F. Scowden</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24b. ADDRESS Rockville, Md.		DATE JUN 16 1966	



1  
FOR STATE  
HEALTH DEPT.

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08705

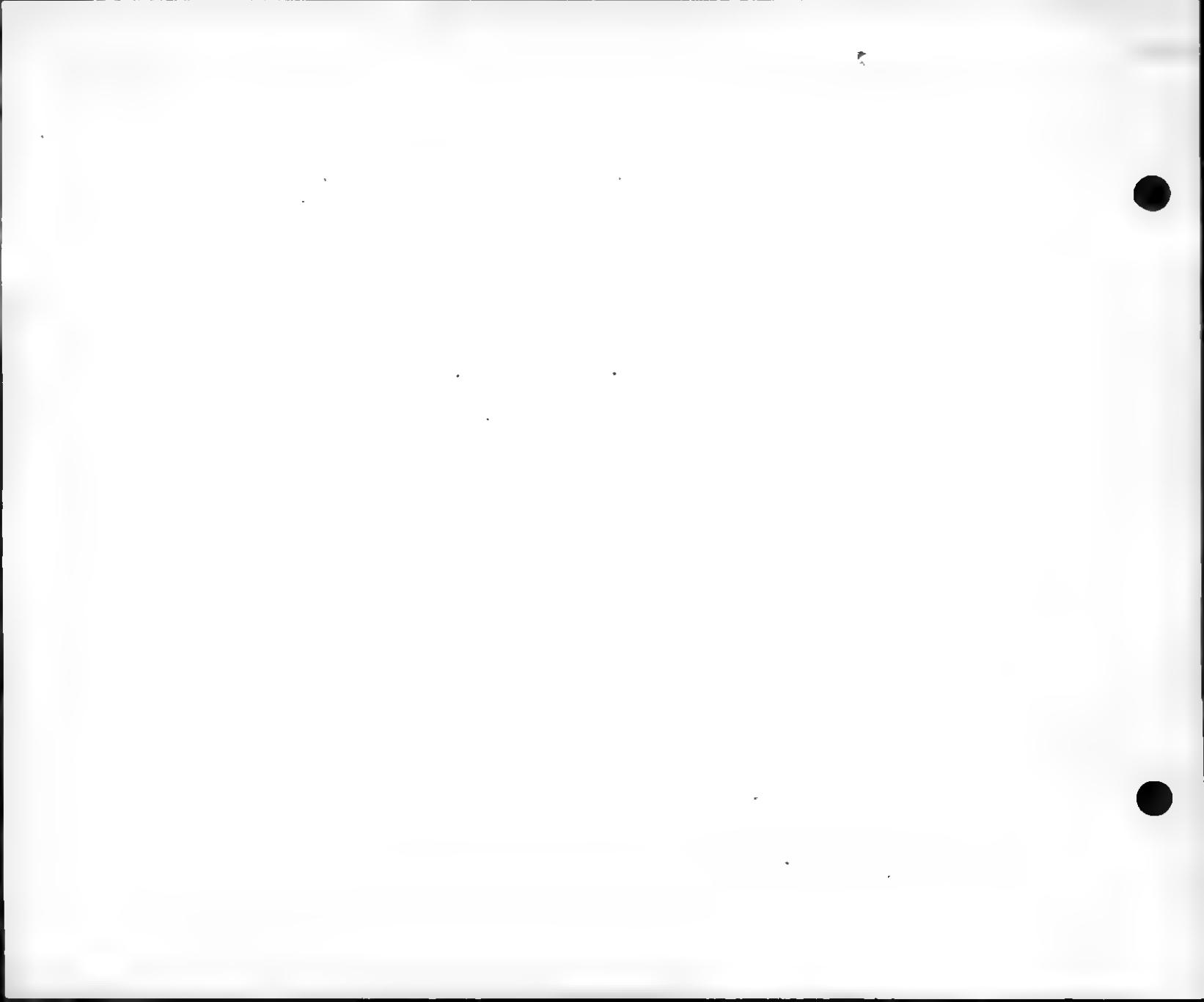
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118695

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased resided if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>13 Cleveland Avenue</b>		d. STREET ADDRESS <b>13 Cleveland Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>WILLIAM JOSEPH Paplousk</b>		First <b>WILLIAM</b>	Middle <b>JOSEPH</b>
3	4	5	6
SEX <b>Male</b>	COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <b>NOV. 2, 1911</b>	W DIVORCED <input type="checkbox"/> DIVORCED <b>54</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AMERICAN RAILWAY EXPRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delivery man</b>	
13. FATHER'S NAME <b>JOSEPH</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>VINCENTA OLSEWSKI</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute asphyxiation due to aspiration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>of vomitus.</b> DUE TO last (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased drinking &amp; wearing neck brace, vomited and aspirated vomitus.</b>	
20c. TIME OF INJURY Month Day, Year 2:00 p.m. 6/18 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Takoma Pk. Montg. Md.</b>		(County) <b>Montgomery</b>	(State) <b>MD</b>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Peap M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD	
EXAMINER'S NAME (Type) <b>BELDEN R. PEAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>Arlington</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial 6-14-66</b>		23b. DATE THEREOF <b>6-14-66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, VA</b>	
24. FUNERAL DIRECTOR <b>Art. Bacon 1722 7th Ave</b>		ADDRESS <b>Arlington, VA</b>	
25a. RECD BY REGISTRAR <b>June 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Scanned for</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08706

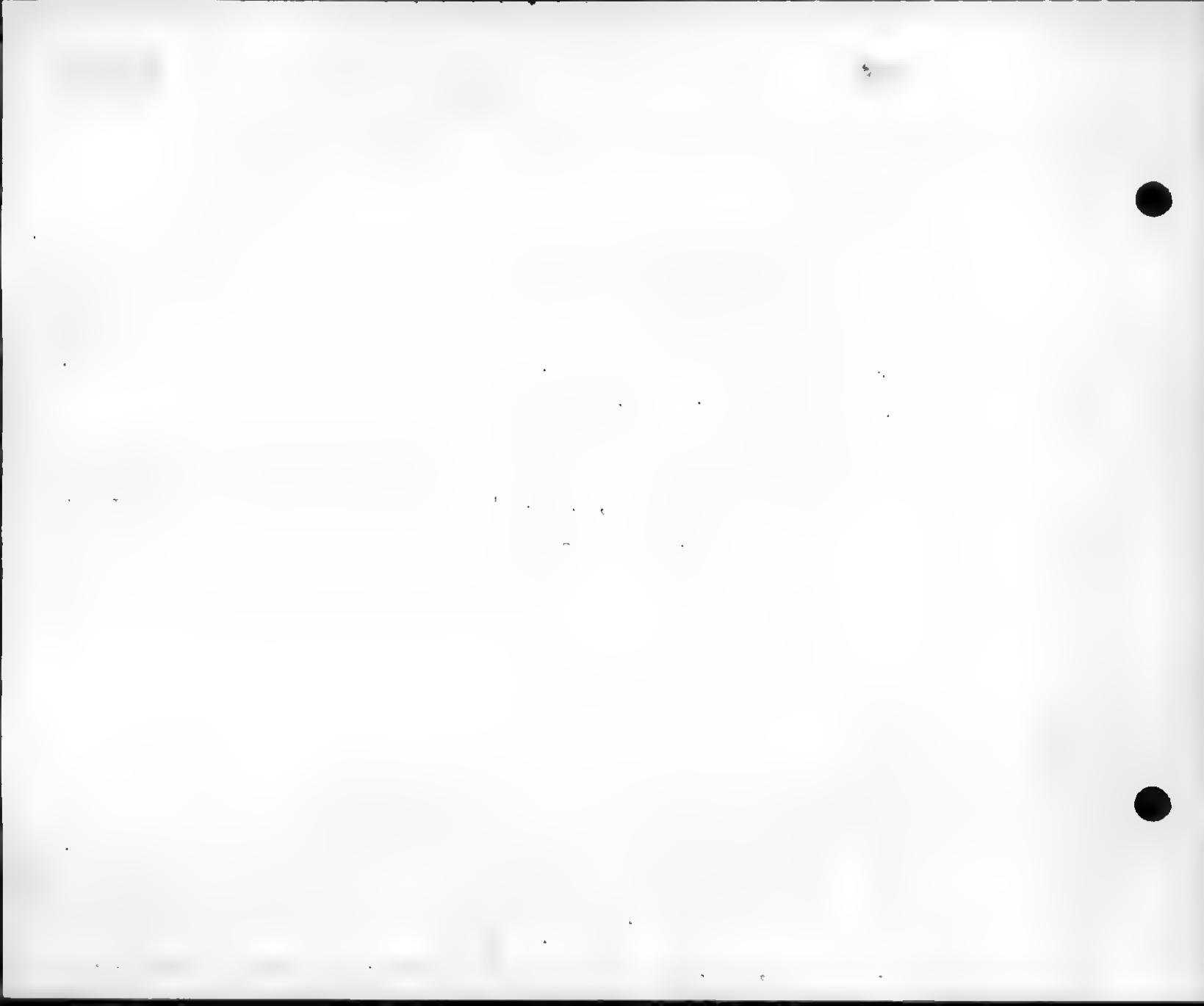
## CERTIFICATE OF DEATH

08696

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. STREET ADDRESS <i>2312 Pennsylvania Ave.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Raymond</i>		First <i>WALTER</i>	Middle <i>Patrick</i>
4. DATE OF DEATH Month <i>June</i>	Month <i>8</i>	Day <i>1966</i>	Year
5. SEX <i>Male</i>	COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9-3-31</i>	9. AGE (In years at birthday) <i>34 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chef</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Bethesda, Md. (old) Welles-Barre, Pa.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Walter Patrick (Pietruszewski)</i>	14. MOTHER'S MAIDEN NAME <i>Frances Maciak</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO <i>201-24-6287</i>	17. INFORMANT <i>Wife - Pauline (Same as above)</i>	INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5811</i>		DUE TO <i>chronic alcoholism</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		DUE TO <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>1300 M</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 30, 1955</i> , to <i>June 8, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 7, 1966</i> , and that death occurred at <i>1300 M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Allen J. O'Neill</i>		22b. DATE SIGNED <i>6-8-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill M.D.</i>		22d. ADDRESS <i>8601 Old Georgetown Rd, Bethesda Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11 June 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>
23d. LOCATION (City or Town) <i>Carverton, Pennsylvania</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		25a. ADDRESS <i>8434 Georgia Avenue</i>	25b. REC'D BY REGISTRAR <i>JUN 13 1966</i>
Warren E. Pumphrey, Inc. Silver Spring, Md.		REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

28703

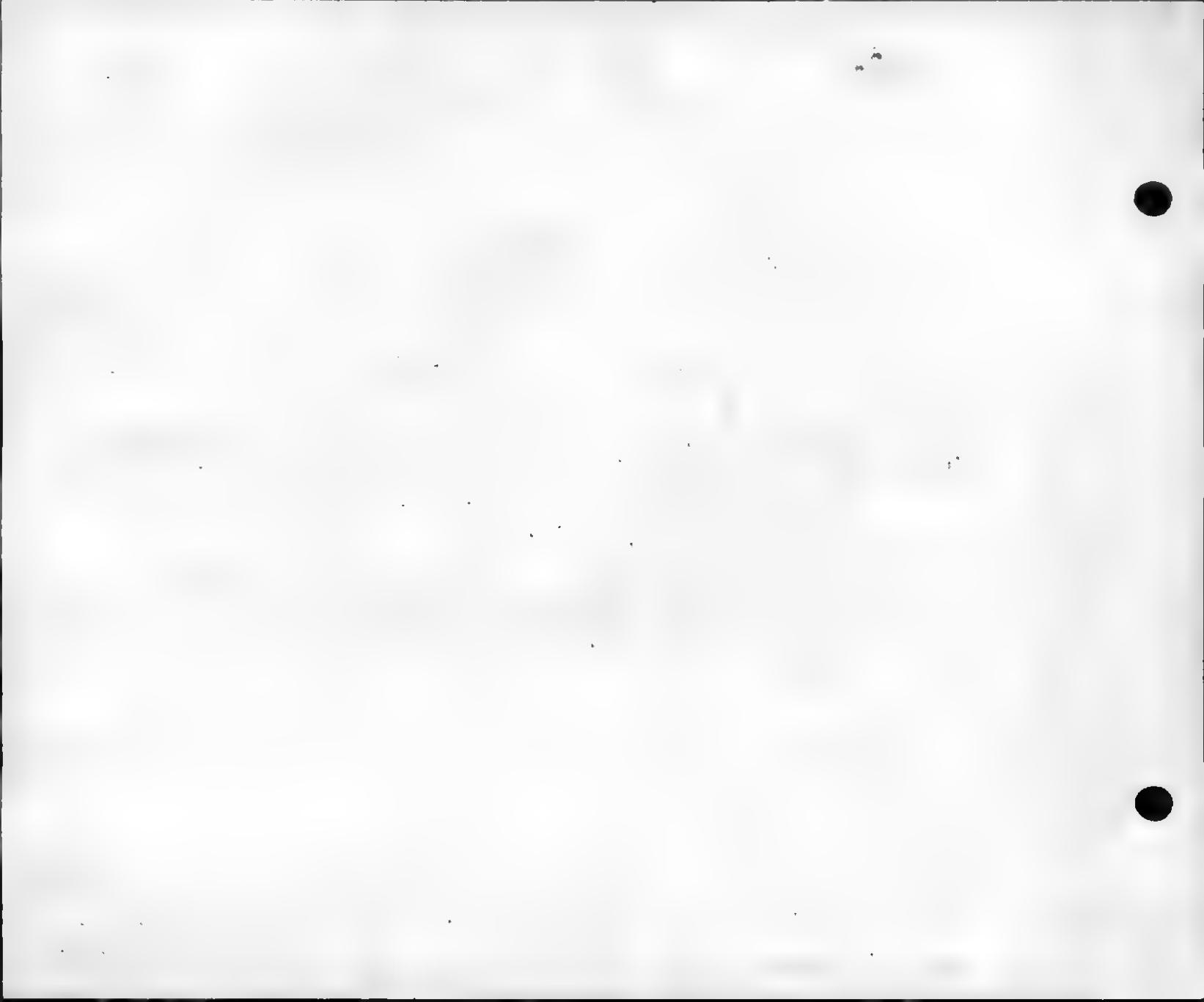
## CERTIFICATE OF DEATH

08517

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be rejoined by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY <i>Prince Georges</i>	
c. LENGTH OF STAY IN Tb <i>6 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lewisdale</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		d. STREET ADDRESS <i>2246 Hannon St.</i>	
3. NAME OF DECEASED (Type or print) <b>MR. FRANK</b>		First <b>B.</b>	Middle <b>Paul</b>
4. DATE OF DEATH <b>June 19 1966</b>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-4-87</i>
		WIDOWED <input type="checkbox"/>	9. AGE (In years last birthday) <i>78 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Realtor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Realestate</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Springfield Ohio</i>	
13. FATHER'S NAME <i>Edward Paul</i>	14. MOTHER'S MAIDEN NAME <i>Mary Morris</i>	12. CITIZEN OF WHAT COUNTRY? <i>America USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	16. SOCIAL SECURITY NO. <i>579-07-8211</i>	17. INFORMANT <i>Grace Paul</i>	Address <i>2266 Hannon Street Lewisdale, Maryland</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
DUE TO  (b) DUE TO  (c)		2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6-13-66</i> , to <i>6-19</i> , 1966, that (I) (we) last saw the deceased alive on <i>6-18</i> 1966, and that death occurred at <i>8:34 A.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Ernest M. Magi</i>		22b. DATE SIGNED <i>6-19-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Ernest M. Magi</i>		22d. ADDRESS <i>831 University Blvd. E., Silver Spring</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 22, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>	
24. FUNERAL DIRECTOR <i>Glen Carter</i>		25a. ADDRESS <i>8434 Georgia Avenue</i>	
		25b. REC'D BY REGISTRAR DATE <i>JUN 22 1966</i>	
		25b. REC STRR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88708

08698

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <b>MONTGOMERY</b>		b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TED PEARMAN</b>		4. DATE OF DEATH Last 6 Month 11 Day 19 Year 66	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/21/36</b>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICAL JOURNEYMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>RICHMOND, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>WASH. D.C.</b>	
13. FATHER'S NAME <b>Ray P. PEARMAN</b>		14. MOTHER'S MAIDEN NAME <b>GAYNELLE JONES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give year or date of service) <b>YES 13/2/56-10/10/57</b>		16. SOCIAL SECURITY NO. <b>579-46-1306</b>	
17. INFORMANT <b>RAY P. PEARMAN 5011 NEBR. AVE</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Multiple Extreme Internal Injuries with Exsanguination due to auto colliding with parked car.</b>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } DUE TO (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, Part II, Item 20a) <b>Deceased driver, collided with parked car at high speed.</b>	
20c. TIME OF INJURY Month, Day, Year <b>12 17 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. CITY OR TOWN (County) <b>Silver Spring, Montgomery, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Belden R. Peap</b>	
ACTUAL SIGNATURE <b>Belden R. Peap</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>	
EXAMINER'S NAME (Type) <b>BELODEN R. PEAP M.D. u/cator</b>		DATE SIGNED <b>JUNE 11, 1966</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 15 1966</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NATL.</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VA.</b>	
23. FUNERAL DIRECTOR <b>H. Don. DeVol 2224 Wisconsin NW 2000</b>		24a. REC'D BY REGISTRAR <b>JUN 16 1966</b>	
ADDRESS <b>Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

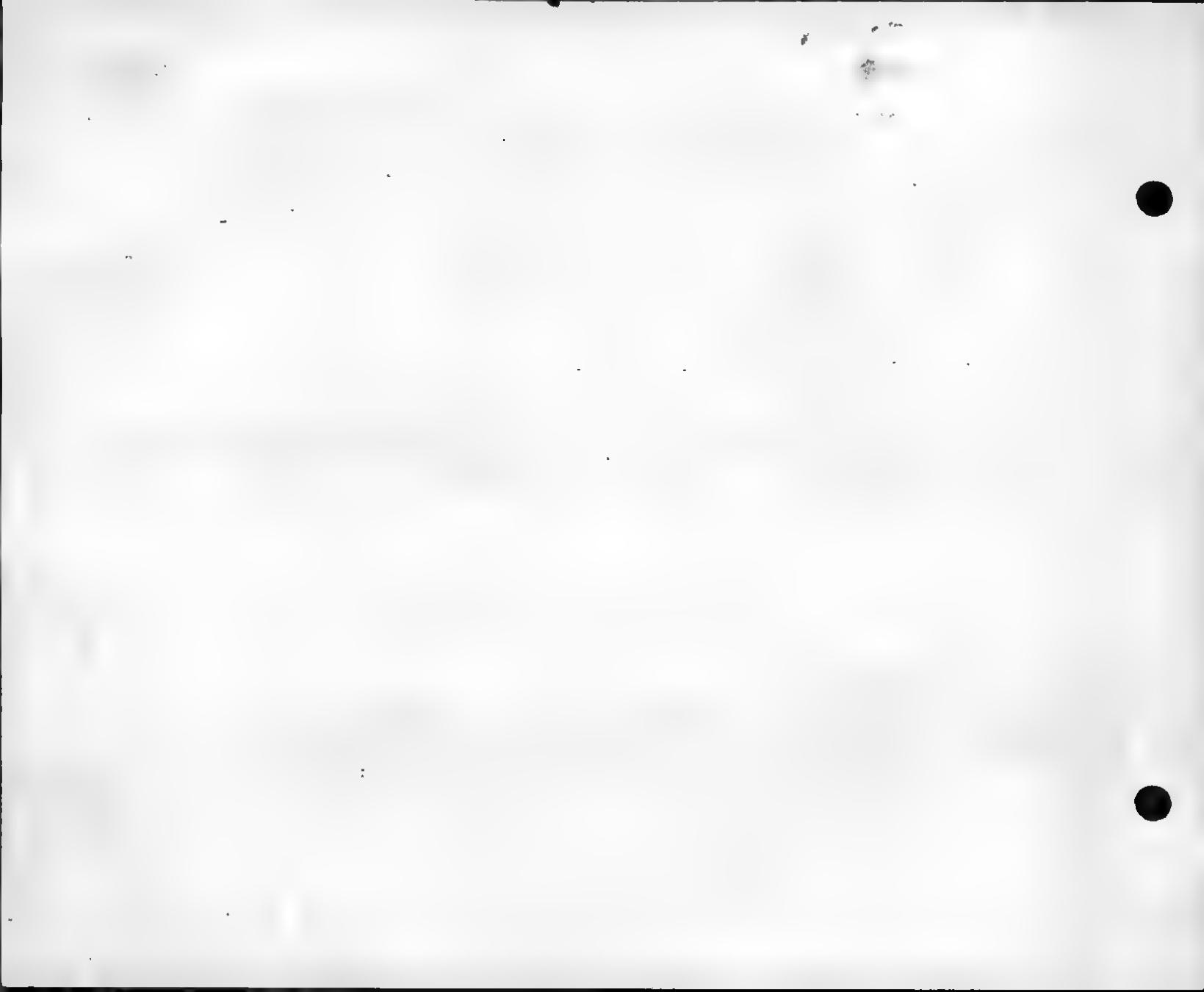
08699

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours of death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Olney</b>	c. LENGTH OF STAY IN lb <b>42 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>4525 Muncaster Mill Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>NMN</b>	Last <b>Peigh</b>		
4 DATE OF DEATH 6	Month 6	Day 23	Year 1966		
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>200000 2-27-06</b>		
9. AGE (In years at last birthday) <b>60 yrs</b>	10. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>	11. IF UNDER 1 YEAR Months <b>0</b>	12. IF UNDER 24 HRS Days <b>0</b> Hours <b>0</b> Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Issac McKenzie</b>	14. MOTHER'S MAIDEN NAME <b>Clara Dodge</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT <b>David Peigh, 4525 Muncaster Mill Rd.</b> <del>4525 Muncaster Mill Rd.</del> <b>Norbeck, Maryland</b>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Peritonitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5/11</b>					
(b) <b>Perforation of stomach</b>		<b>24 hrs.</b>			
(c) <b>Use of levine feeding tube</b>		<b>1 wk.</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>left hemiparesis, basilar artery insufficiency, diabetes mellitus</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter date of injury in Part I or Part II of item 18) <b>6-23-1966</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Rockville</b>	(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that (1) (this hospital) attended the deceased from <b>5-9-1966</b> to <b>6/23-1966</b> , that (1) (we) last saw the deceased alive on <b>6-23-1966</b> , and that death occurred of <b>5:30P</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Frederick Moomaw</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>6-24-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Frederick Moomaw</b>	22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 27, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) <b>Rockville, Montgomery, Md.</b>	(County) <b>Maryland</b>	(State) <b>MD</b>
24. FUNERAL DIRECTOR <b>John B. Thomas 8434 Georgia Avenue Warren E. Pumphrey, Inc., Silver Spring, Md.</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>1111N 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

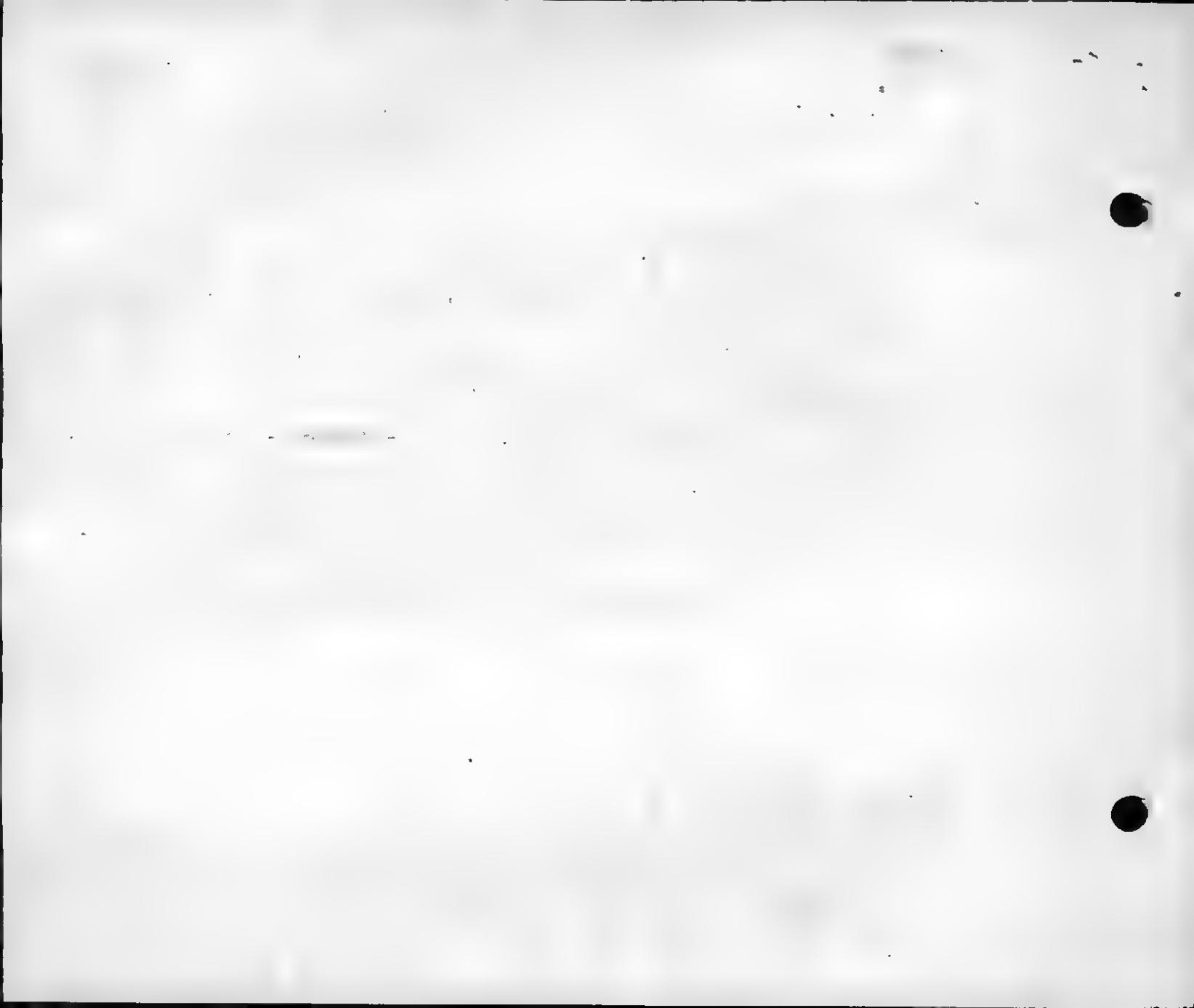
**CERTIFICATE OF DEATH**

08710

08700

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death  
 Page 4  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND		
b. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b ??		b. COUNTY		Montgomery		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4007 Randolph Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS		11506 Connecticut Avenue		
3. NAME OF DECEASED (Type or print) ESTHER		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
S. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1893	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Wilfson		14. MOTHER'S MAIDEN NAME Varina Winternitz						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edgar Perretz- Son		Address Same as Item #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 DAY		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) 8/12/63		(County) (State) 6/7/66
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6/6/1966, and that death occurred at 12 M, from the causes and on the date stated above								
22a. SIGNATURE DAVID GOLDENBERG		M.D. <input type="checkbox"/> ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/>		22b. DATE 6/7/66		
22c. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG		STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 10620 Georgia		6/7/66		
23a. BURIAL, CREMATION OR REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/7/1966		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 8 1966		25b. REGISTRAR'S SIGNATURE J. Charles J. Judge		



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M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08711

CERTIFICATE OF DEATH

08701

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MARYLAND</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESMOR SANITARIUM &amp; HOSPITAL</b>		d. STREET ADDRESS <b>2701-36th St., N.W.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) <b>William L. Peters</b>				
4. SEX <b>Male</b>	5. COLOR OR RACE <b>White</b>	6. MARRIED WIDOWED <input type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Feb. 18, 1898</b>		9. AGE (In years last birthday) <b>68</b> yrs	10. DATE OF DEATH Month <b>June</b>			
10. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Salem, New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Peters, Richard</b>		14. MOTHER'S MAIDEN NAME <b>Nora Lillis</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	17. INFORMANT Address <b>Wife &amp; Son</b> <b>Same as 2d</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Disease</i> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Arteriosclerotic Heart disease</i> DUE TO (c) <i>Cerebral Vascular accident</i>						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>at home</i>	20f. (City or town) <i>16</i>	(County) <i>16</i>	(State) <i>16</i>
21. I certify that (I) (this hospital) attended the deceased from <i>1/80/46</i> to <i>1/80/46</i> , 1946, that (I) (we) last saw the deceased alive on <i>1/80/46</i> , and that death occurred at <i>1/80/46</i> M, from causes and on the date stated above.						
22a. SIGNATURE <i>Stephen F. Vergez</i>		22b. DATE SIGNED <i>1/80/46</i>				
22c. PHYSICIAN'S NAME (Type) <i>5721 - Professor Stephen F. Vergez</i>		22d. ADDRESS <i>Arlington Nat Cem</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jul 5, 66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Nat Cem</b>	23d. LOCATION (City or Town) <b>Arlington Co., Va.</b>	(County) <b>16</b>	(State) <b>16</b>
24. FUNERAL DIRECTOR <i>See Funeral Home - Washington D.C.</i>		ADDRESS <i>See Funeral Home - Washington D.C.</i>		25a. REC'D BY REGISTRAR <b>JUL 5 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) M 1/66						



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

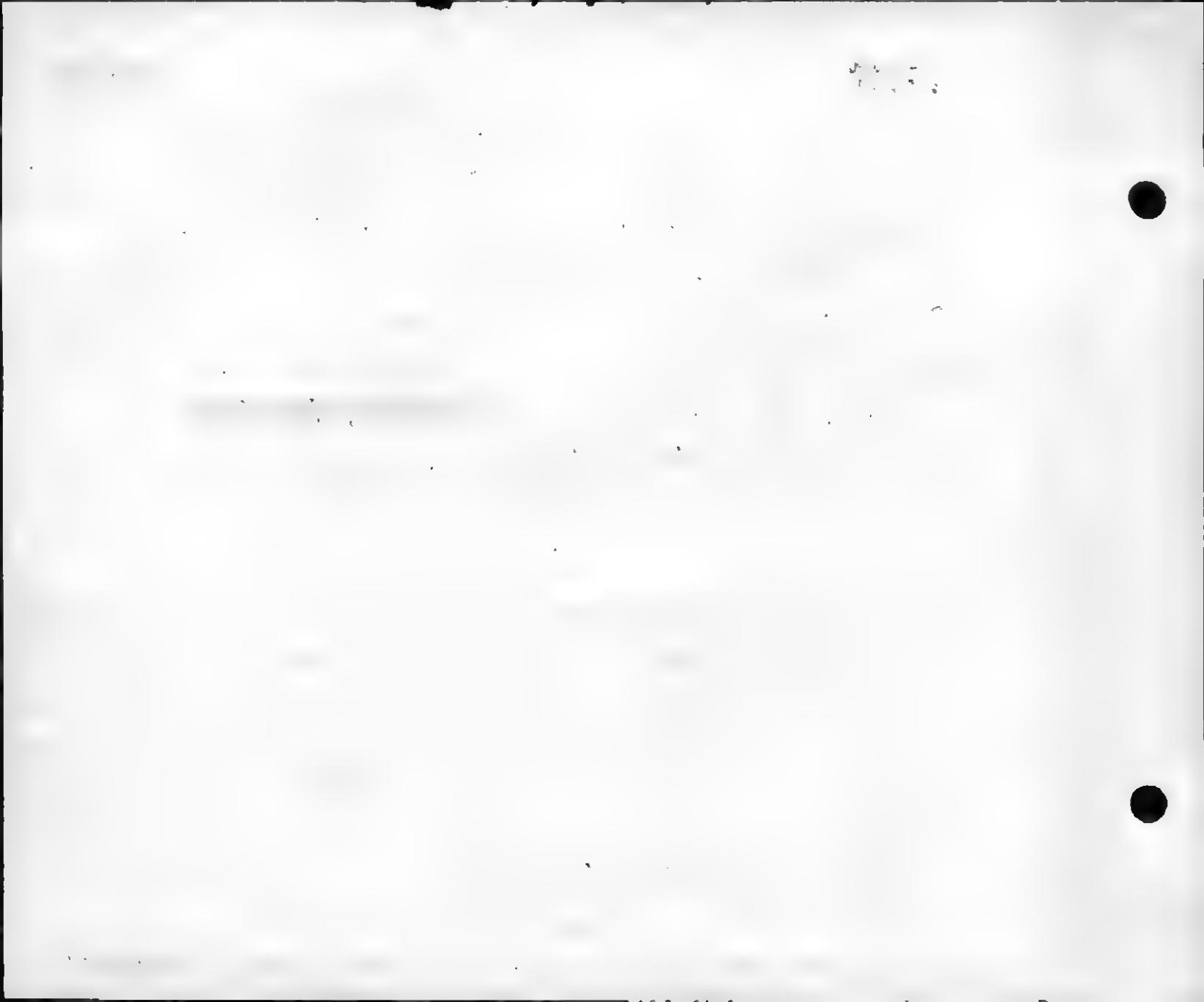
C8712

## CERTIFICATE OF DEATH

118702

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.  
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1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>3 MONTHS 1 DAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fairland Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>RUTH</b>	Middle <b>E. PETTINGILL</b>	4. DATE OF DEATH Month <b>6</b> Day <b>12</b> Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-14 1906</b>
9. AGE (In years lost birthday) yrs <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Prince George, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F Smith</b>		14. MOTHER'S MAIDEN NAME <b>LAURA PERRIE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-10-2849</b>	
17. INFORMANT		Address <b>Pearl A. Pfieger Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1908</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO <b>Metastatic Carcinoma of the Breast</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6/12 1966</b>
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>3/13/1966</b> to <b>6/12/1966</b> , that (I) (we) last saw the deceased alive on <b>6/11/1966</b> , and that death occurred at <b>5:00 P.M.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>Boris Rabkin</b>		22b. DATE SIGNED <b>6/12/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Boris Rabkin, M.D.</b>		22d. ADDRESS <b>1019 University Blvd East</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/15/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>IN 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 9 Years							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4116 Wexford Court				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington							
3. NAME OF DECEASED (Type or print) SARAH BLANCHE				First		Middle		Last PICKRELL		4. DATE OF DEATH JUNE 15 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED		NEVER MARRIED DIVORCED		8. DATE OF BIRTH Jan. 21, 1950		9. AGE (In years last birthday) 16 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.			
13. FATHER'S NAME George McCaw Pickrell, III				14. MOTHER'S MAIDEN NAME Gladys Moss				12. CITIZEN OF WHAT COUNTRY? U. S.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Father		Address Same as George McCaw Pickrell, III			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) High Hydrotherapy (c) Metastatic (neuroblastoma) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) d) Astrocytoma (cured) Ependymoma											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) KENSINGTON, MD. 20995		(County) Baltimore County		(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1963 to 6-15-1966, that (I) (we) last saw the deceased alive on 6-15-1966, and that death occurred at 6-15-1966, M, from the causes and on the date stated above.											
22a. SIGNATURE Robert T. Thibadeau											
22c. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU		22d. ADDRESS KENSINGTON, MD. 20995		22e. DATE SIGNED 6-15-66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-15-66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl. Cem.		23d. LOCATION (City, town or county) Arlington, Virginia		(State)			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, BETHESDA, MARYLAND		ADDRESS ROBERT A. PUMPHREY, BETHESDA, MARYLAND		25a. REC'D BY REGISTRAR UN 17 1956		25b. REGISTRAR'S SIGNATURE Charles Judge					



1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

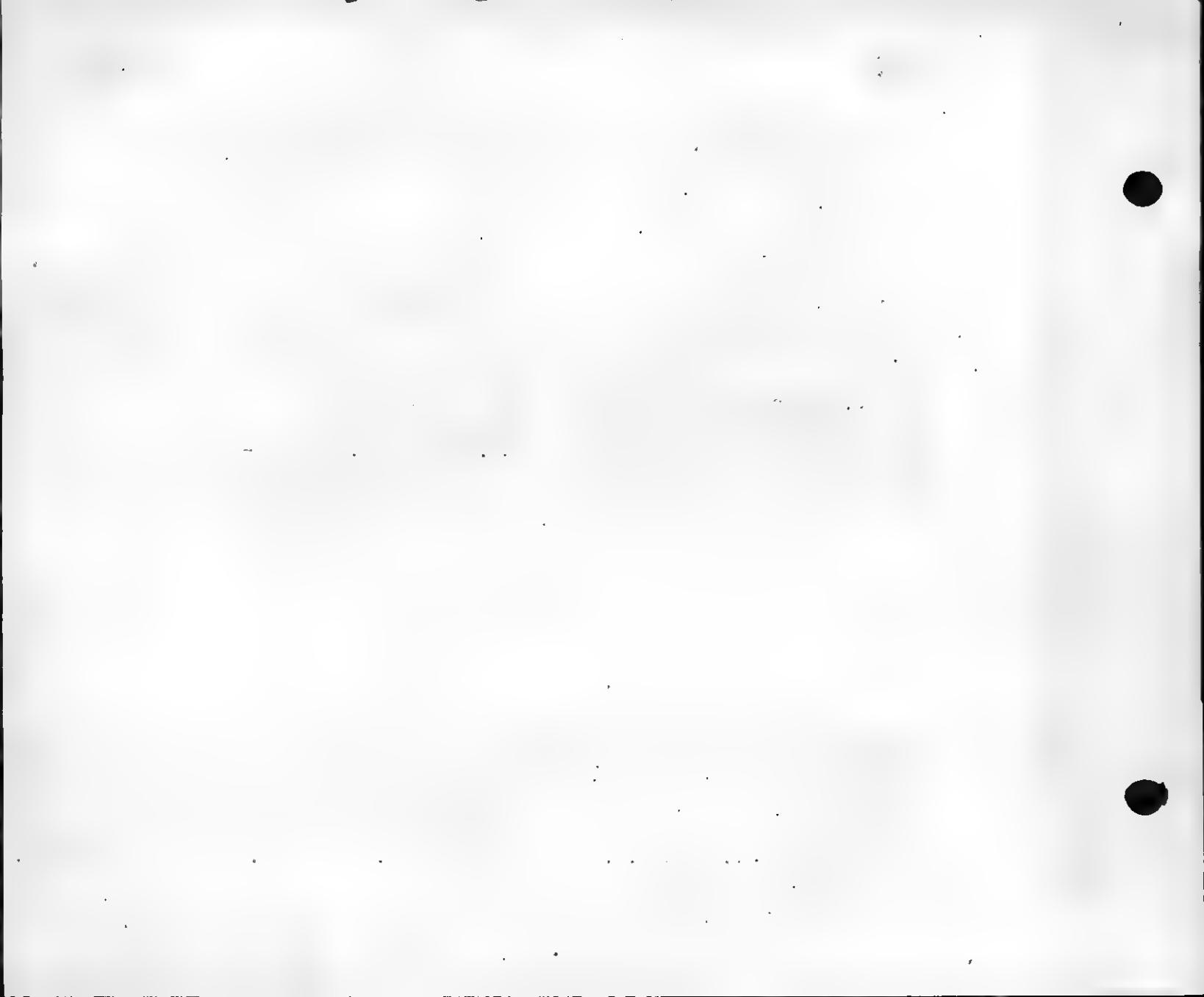
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>8715 Lucy Branch Rd.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Louis</i>		First <i>L.</i>	Middle <i>W.</i>	Last <i>Pierce</i>	4. DATE OF DEATH <i>9-24-12</i>	Month <i>53</i>	Day <i>6</i>	Year <i>1966</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-24-12</i>	9. AGE (in years last birthday) <i>53</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	13. Minutes <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mgr.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Peoples Drug Store</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Henry V. Pierce</i>		14. MOTHER'S MAIDEN NAME <i>Belle Pierce</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>yes</i> <i>WW II</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Barbara E. Pierce - Wife</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
		DUE TO (b)		<i>Hypertension</i>		5-6 yrs			
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>1 June 1966</i> , that (I) (we) last saw the deceased alive on <i>1 June 1966</i> , and that death occurred <i>12:04 P.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>William D. Aud</i>		22b. DATE SIGNED <i>6/1/66</i>							
22c. PHYSICIAN'S NAME (Type) <i>William D. Aud, M.D.</i>		22d. ADDRESS <i>9006 Colesville Rd., Silver Spring, Md.</i>							

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sept 3/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Calvary</i>	23d. LOCATION (City, town or county) (State) <i>Richmond Va.</i>
24. FUNERAL DIRECTOR <i>Joseph W. Bliley</i>	ADDRESS <i>Richmond, Va.</i>	25a. REC'D BY REGISTRAR <i>JUN 6 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08715

CERTIFICATE OF DEATH

08705

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>15 Days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ARCHIBALD</b>		First <b>B.</b>	Middle <b>POORE</b>	
4. DATE OF DEATH <b>JUNE 29</b>	Month <b>1966</b>	Doy <b>3</b>	Year <b>66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <b>WIDOWED</b>	8. NEVER MARRIED <b>DIVORCED</b>	
9. AGE (In years lost birthday) <b>70 yrs.</b>	10. DATE OF BIRTH <b>3/29/96</b>	11. IF UNDER 1 YEAR Months <b>3</b>	12. IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEET METAL</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Daley HOPPER CO.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH POORE</b>		14. MOTHER'S MAIDEN NAME <b>VERGIE ROBEY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NAVY</b> <b>FIRST WAR</b>		16. SOCIAL SECURITY NO. <b>216-01-1356</b>	17. INFORMANT Address <b>JANE I. POORE - Wife-Same as Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, massive 16 days</b> 4201 DUE TO (b) <b>Coronary artery occlusion 16.0</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Year</b>				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 14, 1966</b> to <b>June 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>June 29, 1966</b> , and that death occurred at <b>9:00 P.M.</b> from causes and on the date stated above.				22b. DATE SIGNED <b>6/30/66</b>
22c. PHYSICIAN'S NAME (Type) <b>ROBERT R. MONTGOMERY</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>5411 CEDAR LANE BETHESDA, MD</b>	
23a. BURIAL, CREMATION, BURIAL (Specify)	23b. DATE THEREOF <b>7/5/1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington</b> <b>Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>	ADDRESS <b>Bethesda, Maryland</b>	25a. REC'D BY REGISTRAR DATE <b>JUL 5 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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08716		CERTIFICATE OF DEATH				118706	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10012 Capital View Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> <u>Walter</u> First <u>S.</u> Middle <u>Pratt</u> (Type or print)		<b>4. DATE OF DEATH</b> <u>Jan 23</u> Month <u>1966</u> Day <u>Year</u>					
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-26-1879</u> <b>9. AGE (In years last birthday)</b> <u>86</u> yrs.		<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>Ret. pres.</u> <b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Wash. D C</u>	
<b>13. FATHER'S NAME</b> <u>Walter S. Pratt Sr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Page</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <u>No</u> <b>(Yes, no, or unknown)</b> <b>16. SOCIAL SECURITY NO.</b> <u>578-03-3896</u>		<b>17. INFORMANT</b> <u>3714 Vanessa St., N.W.</u> <b>Address</b> <u>daughter (Mrs. James DeCost)</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>IMMEDIATE CAUSE</b> (a) <u>4201</u> <b>DUE TO</b> <u>myocardial infarct</u> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>cerebral thrombosis</u> <b>DUE TO</b> <u>generalized A.S.</u> (c)	
<b>20c. MEDICAL CERTIFICATION</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>cerebral thrombosis (9 days)</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH</b> <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		<b>20d. TIME OF INJURY</b> Month, Day, Year Hour o.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. <b>at work</b> <input type="checkbox"/> <b>at work</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>533A M.</u>		<b>20f. (City or town)</b> <u>6-23, 1966</u> <b>(County)</b> <u>Rockville</u> <b>(State)</b> <u>Maryland</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>7-15</u>, 1965, to <u>6-23</u>, 1966 that (I) (we) last saw the deceased alive on <u>6-22</u>, 1966, and that death occurred at <u>533A M.</u> from causes and on the date stated above.         </b>						<b>22b. DATE SIGNED</b> <u>6-23-66</u>	
<b>22a. SIGNATURE</b> <u>D. J. Sengstack M.D.</u>		<b>22d. ADDRESS</b> <u>9241 Columbia Blvd.</u> <b>SILVER SPRING,</b> <u>MARYLAND</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>G. L. Sengstack</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>June 25, 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <u>Parklawn Cemetery</u>				<b>23d. LOCATION (City or Town)</b> <u>Rockville</u> <b>(County)</b> <u>Maryland</u> <b>(State)</b>	
<b>24. FUNERAL DIRECTOR</b> <u>C. Glen Clark, 8434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				<b>25a. RECD BY REGISTRAR</b> <u>Charles Judge</u> <b>DATE</b> <u>JUN 27 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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